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The Use of Patient Feedback in the Management of Hospitals in the National Health Service in England

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Comments, Compliments and Complaints:

**The Use of Patient Feedback in the Management of
Hospitals in the National Health Service in England**

Robert Lee

Thesis submitted for the award of PhD degree at King's College London

Abstract

Feedback from patients has become increasingly important in the provision of health care and the management of health services in many countries in the last 30 years. Government policy in England and the published research literature from different countries have focused more on the collection than on the use of patient feedback. There are significant gaps in the research literature relating to the ways in which patient feedback is used in the management of health services. The purpose of this research is to examine how feedback from patients is (or is not) used in the management of hospitals in the National Health Service in England.

This thesis contains the results of a qualitative study of the use of patient feedback in two purposively selected NHS foundation trusts in England. Data were collected through interviews with managers, from government and Trust documents and websites, and through the observation of meetings.

The findings show that qualitative feedback about patients' subjective experience of their illness and services is used by managers to engage with and motivate staff, but that the quantified results of surveys are used to establish criteria and standards for service improvement. Although compliments and commendations by patients are used to praise staff they are not used to help set explicit standards for service improvement. Boards of directors sometimes use feedback from patients to help set strategies for quality improvement, but appear not subsequently to use that feedback explicitly to monitor the implementation of these strategies or assure the quality of services.

The thesis fills gaps in the published literature by demonstrating that, although patient feedback is used in a variety of ways in the management of staff and in the development of strategies to improve the quality of services, managers in general and boards of directors in particular do not always use that feedback systematically to assure and improve the standards of service for patients.

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Preface and Acknowledgements

The original idea for this research came in 2009 when I had been patient for a week in my local hospital. After I was discharged I wrote a letter to the chief executive, praising some aspects of my treatment and care and making some suggestions for improvements. Soon afterwards I was looking for an idea for a PhD and realised that, despite almost 40 years working in and around the Health Service, I did not really know how feedback from patients was used in the management of services. This was the starting point of this study.

The fieldwork for this research was undertaken in two NHS foundation trusts in England. Access for interviews, documents and observation of meetings held in private was granted on condition that the Trusts and individual members of staff would not be identified through this thesis or other publications arising from the research. The two Trusts and their hospitals have therefore been given pseudonyms (Hillside Hospital and Northbank Hospitals). All interviewees and members of staff who are quoted in the thesis have been given generic rather than individual job titles and are referred to by initials that are pseudonyms rather than referring to their actual names. When pseudonyms have been used within quotations in the findings chapters of the thesis they are shown in italics.

I am very grateful to everyone who has advised and supported me in this research, especially my supervisors Juan Baeza and Naomi Fulop, the managers and staff in the two NHS Foundation Trusts who participated in the study, and my wife Pam Lee. Thank you.

Chapter 1 Introduction

1.1 Context: Patient Feedback Practice and Policy

Managers of health services in England and many other countries collect and use feedback from patients about the services the patients have used. In the 30 years since the 1980s many new systems for collecting patient feedback – complaints procedures in hospitals, public and patient involvement forums, local involvement networks, foundation trust membership schemes, surveys of patients, comments and suggestion schemes, mystery shoppers, and ‘real-time’ electronic feedback – have been developed and put in place in the National Health Service (NHS) (Bruster et al. 1994, Bullen and Reeves 2002, Care Quality Commission 2009, Brown et al. 2009). Although the focus in these initiatives has often been more on the collection than the use of feedback (Brown et al. 2009), the way in which feedback is used once it has been collected is an equally important practical matter. Examples of good practice, in both the collection and the use of patient feedback, are beginning to be shared within the NHS (NHS Institute for Innovation and Improvement 2013). Hospitals in the NHS now frequently report in wards and clinics on the use of feedback from patients in terms of ‘You said ... We did ...’.

Government policy about the National Health Service in England before about 2000 focused more on the organisational processes through which patients’ views were expressed than on the ways in which feedback was used in the management of services. Policy has recently focused on collecting simple, immediate feedback, culminating in the one survey question – would you recommend this service to friends and family who need similar treatment or care? – introduced as the Friends and Family Test in April 2013. But policy since about 2000 has also begun to identify ways in which feedback should be used. Hospital authorities were legally required under the Hospital Complaints Procedures Act of 1985 to have complaints procedures; the NHS Plan of 2000 was the first statement of government policy that the NHS should learn from complaints to improve services (Department of Health 2000). The Health and Social Care Act 2001 required all NHS bodies to involve patients and service users (or their representatives) in the planning and provision of services. Following earlier academic surveys, the Department of Health commissioned in 1998 a series of surveys ‘designed to contribute to monitoring performance of the NHS, as seen from the patients’ perspective’ (Bullen and Reeves 2002).

In the mid-2000s policy shifted from using surveys as a tool for performance management to seeing them as feedback to be used locally to support service

improvement (Department of Health 2004, 2007a, 2008a). Since the mid-2000s there has been increasing emphasis in government policy not simply on the collection of immediate short-term feedback but also on its use in 'customer care' and the management of services (Department of Health 2009a). And at the same time, in the wake of the Mid Staffordshire Hospitals crisis in the mid-2000s (The Mid Staffordshire NHS Foundation Trust Inquiry 2010; The Mid Staffordshire NHS Foundation Trust Public Inquiry 2013), there has been increasing emphasis on listening to patients and relatives as a means of assuring safety and improving the quality of care. The stated purpose of the Friends and Family Test is: 'The feedback gathered through the FFT is being used in NHS organisations across the country to stimulate local improvement and empower staff to carry out the sorts of changes that make a real difference to patients and their care.' (NHS England 2015) The assertion that patient feedback is used to stimulate local improvement in health services is one of the issues I will examine in this thesis.

Policy and practice in the NHS have tended over the years to focus on the collection of feedback from patients and the organisational arrangements for involving patients in the provision and management of services rather than on the ways in which feedback is actually used in the management of services. Managers and policy makers often assume that feedback should be used to improve services, without saying how it should be used to achieve this objective and without identifying other objectives to which the use of feedback might contribute. My aim in the present research is to focus more explicitly on the different ways in which feedback from patients is used, or is not used, in the management of health services, to help shift the focus from the collection of feedback to the use of feedback.

1.2 Patient Feedback Research

Alongside the development of practice and policy about the collection and use of feedback from patients in health services, the last 30 years have witnessed an increasing number and variety of research studies in the United Kingdom and other countries about different kinds of patient feedback. The focus of the research has been mainly on different kinds of patient feedback – complaints, local surveys, patient involvement initiatives – rather than on the use of patient feedback (Bruster et al. 1994, Mulcahy and Titter 1998, Reeves and Seccombe 2008). Studies of influences on the use of patient feedback have tended to focus on surveys of patients and on the immediate organisational and managerial factors that influence the use of feedback, rather than on how feedback is actually used in practice (Davies and Cleary 2005). The published literature (e.g. Tasa et al. 1996, Reeves and Seccombe 2008)

often assumes that the purpose of using feedback is to improve services, but does not examine what is meant by 'improvement'. The literature does not systematically examine how feedback from patients is used in the management of health services; this issue, with its empirical and conceptual components, is the starting point of the present research.

Nearly all of the published research about patient feedback is empirical rather than theoretical in orientation. The research has tended to focus on the collection and analysis of data from surveys or operational systems within services that can be used directly to improve the quality of those services. More theoretically informed approaches often see complaints and other forms of patient feedback as examples of consumerism in public services (Stacy 1974, Allsop and Jones 2007) or as drawing on theories of direct and indirect user involvement in services (Tritter 2009, Greenhalgh et al. 2011). But there has, in the published research literature, been very little careful analysis of the ways in which feedback from patients is actually used in the provision and management of hospital services. It is the opening argument of this thesis that the study of the use of patient feedback will usefully draw not only on previous empirical findings about different kinds of feedback but also on careful conceptual analysis of the nature of patient feedback and the ways in which it is used.

My focus in this research is on hospitals in the NHS for two main reasons. First, the focus is on hospitals because much of the previous research about patient feedback in the UK and world-wide has focused on hospitals rather than primary care or community health services. This means that there is a significant body of empirical research findings on which to build the present study; but as I have already argued the extent of this literature about patient feedback in hospitals also reveals much about its empirical nature and lack of conceptual or theoretical underpinnings. The existing research literature about feedback in hospitals provides sources of data that can be interrogated to help develop the conceptual analysis in the present study. Second, the focus is on hospitals because much government policy and management practice in the collection and use of feedback has focused on hospitals in the NHS rather than on other kinds of service. Individual hospitals, as large organisations that often employ thousands of staff and see hundreds of thousands of patients in any one year, are complex organisations with demanding issues of management and governance. This means that the study of the use of patient feedback in these large organisations is itself challenging and exciting, and that the research has the opportunity of contributing to management knowledge and practice in the context of complex organisations and public services more generally.

1.3 Statement of Purpose

This Introduction has argued that policy, practice and the previous published research about patient feedback in health services have focused more on the collection and the contents of patient feedback than on the use of feedback in the management of services. Policy-makers and applied researchers tend to assume that feedback from patients is collected in order to help improve health care; but little attention has been paid in the literature to how feedback is used to achieve this objective and whether feedback is also used to achieve other objectives. The research literature does not systematically examine how patient feedback is used in the management of health services. The research literature is also primarily empirical rather than theoretical in orientation; it does not carefully analyse the nature of feedback and the way in which it is used in the management of services. The intention of this thesis is to help fill these gaps in the policy and academic literatures. The aim of the research is to examine how feedback from patients is used, or is not used, in the management of hospitals in the NHS in England.

This research will contribute to the published research literature in two ways. It will extend and develop the empirical analysis of the use of patient feedback in the management of health services, generating new findings about the different kinds of patient feedback and how they are used in the management of hospitals. And it will help establish the foundations of a more careful and rigorous conceptual analysis of the nature and use of patient feedback. These empirical and conceptual contributions are an essential first step in preparing the way for further empirical and theoretical research aiming to explain why patient feedback is (or is not) used in particular ways and to understand the effects of feedback from patients on the quality and development of health care and health services.

1.4 Organisation of the Thesis

In Chapter 2 I review the published research literature about the collection and use of feedback from patients. I argue not only that the research has focused on the collection rather than the use of patient feedback but also that it has also tended to assume, without much deeper analysis, that the purpose of collecting feedback is to improve health care and health services. I therefore also review recent public service improvement literature in order to identify a conceptual framework for analysing the ways in which patient feedback might be used to improve health services. Chapter 2 ends with a statement of the research questions that I address in this thesis.

In Chapter 3 I identify and justify the methodological strategy adopted in the research to examine my research questions. I then describe the methods of data collection and analysis I used to translate this strategy into the empirical study and the findings presented in this thesis.

In Chapters 4 to 6 I present the empirical findings of my research. In Chapter 4 I examine two contrasting uses of patient feedback: the use of feedback to improve patients' subjective experience of services; and the use of feedback to improve the quality and delivery of services as defined by service providers and managers. I show that managers use the number of complaints and numerical aspects of feedback from patient surveys as indicators of Trusts' performance. They often define improvement itself in terms of the numerical results of surveys and reductions in the number of complaints, rather than in terms of patients' subjective feelings about and experience of services.

In Chapter 5 I show that managers use the subjective aspects of patients' experience to engage with and motivate staff. They use complaints and negative feedback in the training and management of clinical and non-clinical staff. Although they use compliments and commendations to thank and praise staff for their work, they do not use this positive feedback explicitly to help set standards for service improvement.

In Chapter 6 I show that Boards of Directors use patient feedback to help set strategies and standards for the quality of services. Boards say that they will use feedback to help assure the quality of services and monitor the implementation of their strategies and improvement initiatives, but I could see little evidence that they do in fact use patient feedback for these purposes.

In Chapter 7 I discuss these findings in the context of the published patient feedback research literature. I argue that my research contributes to our knowledge by deepening the analysis of the criteria and standards by which the use of patient feedback to improve health care is judged, and by filling significant gaps in the literature about the ways in which feedback is used to influence and manage clinical and non-clinical staff in hospitals and the ways in which it is used (or not used) by boards of directors of NHS foundation trusts to help assure the quality of services. I then examine the implications of my study for the development of policy and practice in the provision of health services and for the development of future research into the collection and use of patient feedback.

Chapter 2 Literature Review

2.1 Introduction

In Chapter 1 I argued that policy, practice and empirical research about patient feedback have tended to focus on the collection of feedback from patients rather than on its use in the management of hospitals and other health services. Policy-makers and researchers often say that the purpose of collecting feedback is to improve services but do not examine systematically what is to be improved and how 'improvement' is to be assessed. My research is intended to help fill these gaps, to provide for the first time detailed empirical evidence about how feedback from patients is actually used in the management of hospitals in the National Health Service. My purpose in this chapter is therefore to review the research literature about the use of patient feedback in the management of health services. After an initial definition of 'patient feedback' I start by examining the research literature about different kinds and different domains of feedback. I next analyse in detail what the research literature says about the use of patient feedback to improve services and what is meant by improvement. I then examine what the literature says about other uses of patient feedback. In the final section of the chapter I summarise the gaps in the research literature and set out a series of research questions to be addressed in this study.

2.2 Patient Feedback: An Initial Definition

Despite the continuing use of the term 'patient feedback' in government policy and practice in the National Health Service, I have found no definitions or conceptual analyses of 'patient feedback' in the research literature or commentaries that I have reviewed for this study. Brown et al. (2009) and Coulter et al. (2009) in reports written for the NHS about patient feedback and patient experience gave many examples of different kinds of feedback but did not examine or define the term 'patient feedback' itself. The Concise Oxford Dictionary (Pearsall 2001) definition of feedback as 'information given in response to a product, a person's performance of a task, etc., used as a basis for improvement' usefully identifies feedback as information about some previous occurrence. But the inclusion in the definition of 'used as a basis for improvement' pre-judges the empirical question 'what is feedback actually used for?' that is the starting point of the present research. Feedback may be used to help improve services, for a variety of purposes other than improvement; or it may not be used at all. 'Patient feedback' is therefore provisionally defined for the purpose of this research as 'information about a patient's use or experience of health services provided (intentionally or not) by the patient (or someone else acting on her / his

behalf) to the provider of those services (or someone working on the provider's behalf).' The inclusion of the terms 'use' and 'experience' in the definition reflects current Health Service policy and practice (Department of Health 2008b, Entwistle et al. 2012) emphasising the objective and subjective aspects of patients' use of health services. The definition also focuses the research on patients' use of health services rather than on their own medical condition or the outcomes of treatment as recorded for example in Patient Recorded Outcome Measures (Department of Health 2008c, Boyce et al. 2014). Feedback exists when the information is transmitted from a patient and received (though not necessarily fully understood or acted upon) by the service provider.

In focusing on feedback from patients it is not my intention to make specific assumptions that patients are passive recipients of treatment as in the medical model of health care, that they are active seekers and users of services, or that they should be seen as customers or consumers of health care (for discussion of these issues see for example Annandale 1998, Callaghan and Wistow 2006, Fotaki 2011a, 2011b). I use the word 'patient' in a broad sense, capable of being associated with any of these meanings, and without pre-judging which set of associations is most relevant in any one context. At the same time, I acknowledge that some of the 'patient' feedback that providers of health services receive and use may not be from patients directly but may come from family members, relatives or other people who consider that they represent the views of patients. The focus of the research is not so much on who provides patient feedback as on how the feedback is used in the management of services.

My focus in the research on the use of patient feedback in the management of health services is intended to differentiate management from the use of feedback in the clinical diagnosis and treatment of individual patients. The research is not about the ways in which doctors and nurses use feedback from an individual patient to help plan or modify that patient's treatment and care. Accepting that the boundaries between care of the individual patient and the provision and management of services may be permeable – feedback during a consultation from a patient to a doctor may be used to support the development of a clinical service; informal feedback to a ward manager may be used to change the way a service is delivered – the focus of the research is on the use of feedback in the management of hospital services. 'Management' is defined for this purpose as the leadership, organisation and control of people and other resources to achieve the defined objectives of an organisation, with an emphasis in Britain at least on the leadership and executive functions rather than the technical or technological skills of managers (Crainer and Dearlove 2004a). The focus of this research is on both the ends and the means in the use of patient

feedback, on the objectives for which patient feedback is used and on the people and organisational processes through which these objectives are pursued.

2.3 Sources of Patient Feedback

My focus in this research is on the use that is made of feedback from patients. This raises the preliminary questions of how we identify and describe patient feedback: is patient feedback all of one kind, collected and used for one overarching purpose; or are different kinds of feedback collected and used for different purposes? To address these questions, we need a conceptual analysis of the different kinds of feedback, not as an end in itself, but as a starting point for examining the different uses to which the different kinds of feedback might be put. This section therefore addresses the preliminary question: what are the main kinds or sources of patient feedback that are identified in the published research literature?

There are very few published research studies that have attempted to identify and analyse systematically the different kinds of patient feedback that are collected and used in the management of health services. The main empirical research study that reports data about different kinds of patient feedback was undertaken in one hospital in the United States in the 1990s. Tasa et al. (1996) called their paper 'Using Patient Feedback for Quality Improvement', which suggests that they implicitly assumed that the main purpose of collecting feedback from patients was to improve the quality of healthy care. They identified five main methods of collecting patient feedback in the hospital.

- In-patient satisfaction surveys; using a questionnaire with three clinical care sub-scales (medical outcome, physician care and nursing care) and four support services measures (comfort and cleanliness, food services, admission and discharge, and courtesy of other staff); leading to quarterly reports.
- The internal complaints and compliments feedback system; comments and complaints were recorded by patients on comment cards available in the hospital; the information was entered on to a database and sent to the appropriate area or service to resolve the issue and respond to the patient.
- Focus groups; consisting of discharged patients to obtain in depth information in a discussion atmosphere.
- Quality improvement team surveys; surveys created by individual quality improvement teams to collect information about the processes they were working to improve.

- Informal comments; including for example telephone calls, threats of law suits, and comments to care givers that were not part of the formal compliments and complaints system.

In identifying these five methods of collecting feedback, Tasa et al. did not provide an analysis of the concepts underpinning this classification or any detailed data showing how they had arrived at it. They reported their empirical findings without saying how they had arrived at the classification. But, in the absence of more systematically analytical alternatives, their list may serve as a starting point for examining the wider research literature about different kinds of feedback and the ways in which they are used in the management of services.

The empirical research literature is consistent with the analysis of Tasa et al. in focusing on surveys of patients, but contains much more information about different kinds of surveys and the uses to which they may be put. The literature identifies: surveys of patients with specific conditions about specific aspects of clinical treatment (e.g. Roberts et al. 1994); surveys about individual clinical services (e.g. Brooker and Dinshaw 1998, Naithani et al. 2006, Patel et al. 2007); surveys about 'hotel' and support services (e.g. Naithani et al. 2008); and surveys about health care or health services more generally (Zimney et al. 1980, Wilde-Larsson and Larsson 2009, Knowles et al. 2011). The survey data may be collected through face to face interviews (Lee 1979, Brooker and Dinshaw 1998, Naithani et al. 2006, Naithani et al. 2008), telephone or automated telephone interviews (Zimney et al. 1980, Knowles et al. 2011), hand-delivered or postal questionnaires (Piersma 1986, Spencer 1996, Reiber et al. 2004, Reinders et al. 2008), or electronic or on-line devices (Larsson 2006, Brown et al. 2009). Questions may be open-ended or closed or seek information in the form of rating scales of various kinds. These surveys have sometimes focused on the collection from patients of specific pieces of information about services, sometimes on patients' views or opinions about specific aspects of services, and sometimes on patient 'satisfaction' or 'patient experience', reflecting different views about what it is that the survey is intended to assess, influence or improve.

The empirical research literature does not follow Tasa et al. in drawing a distinction between (generic) patient satisfaction surveys and surveys undertaken as part of specific quality improvement initiatives. That distinction appears to reflect a view that satisfaction surveys are intended to help identify whether or not there are problems in a service and that quality improvement surveys are designed, once an improvement initiative has been established, to identify the nature of the problems in more detail and / or to monitor the effectiveness of the initiative. The literature does

however often reflect a distinction between surveys commissioned by national governments or agencies and undertaken with the aim of comparative analysis and performance management on a nation-wide basis in the UK (Bruster et al. 1994, Bullen and Reeves 2002, Raleigh et al. 2009, Raleigh et al. 2012) or other countries (Miseviciene and Milasauskiene 2003, Bjertnaes et al. 2012) and surveys designed and undertaken locally for local service improvement purposes (Spencer 1996, Jorde and Nordoy 1999, Davies et al. 2008). Different kinds of surveys appear to some extent to be undertaken for different purposes: satisfaction surveys to help in the initial identification of problems; local surveys to help analyse the detailed nature of problems and to monitor progress in resolving them; national surveys to support the comparative analysis and performance management of organisations.

Much of the empirical research literature about patient feedback focuses on formal complaints that are logged and recorded on health service organisations' information systems. Many authors in the UK (e.g. Hunt and Glucksman 1991, Pietroni and De Uray-Ura 1994, Bark et al. 1994, Allsop and Jones 2007), in Australia (e.g. Anderson et al. 2000, Taylor et al. 2002, Parry and Hewage 2009), in the United States (e.g. Cooke 1976, Desai 2010) and in other countries (e.g. Hsieh et al. 2005, Friele et al. 2008) have drawn on and used officially recorded data to examine the causes and frequency of complaints. These authors then argue that information from complaints helps to identify problems in the provision of services and areas where improvements are needed.

One set of studies about patients' complaints has focused particularly on doctors' responses to complaints. Studies in Australia and New Zealand (Cunningham and Dovey 2000, Cunningham 2004, Cunningham and Dovey 2006 Jarvis and Frizelle 2006) as well as the UK (Jain and Ogden 1999) have emphasised the negative emotional and professional responses of doctors to complaints. These responses mean that the doctors use information from complaints not necessarily to improve the quality of services but to practice defensive medicine (e.g. by ordering unnecessary investigations or by making unnecessary referrals to specialists) and sometimes by withdrawing from areas of clinical practice that they perceive as being a high risk. Allsop and Mulcahy (1998) studied the way in which doctors responded to complaints by defining what was and what was not professional knowledge and by defending their professional identity. Although these studies have focused on doctors rather than nurses, therapists or other groups of staff, they are significant from the point of view of the present research because they focus on the role of clinical and non-clinical staff in the use of feedback from patients. Feedback is not simply used in some kind of depersonalised organisational process in the management of

services; it is individual members of staff, whether clinicians or managers, who have a stake in the provision of the existing service and who then do or do not use feedback from patients in the management of that service.

Although some authors (e.g. Bismark et al. 2011, 2013) have used findings from complaints systems to argue that doctors should use information from complaints to improve their practice and the quality of services, the findings of Cunningham and others do mean that it is important not to assume that feedback is always simply used to improve services. The finding that feedback is not always used to improve services means that it is important to examine how feedback is actually used in practice. The argument also means that it is important to be explicit about the nature of 'improvement'; it may be that a reduction in risky practice that may give rise to complaints is not only defensive but is also at the same time an improvement in services. I will examine these questions about improvement more closely in Section 2.5 of this chapter.

Although Tasa et al. (1996) reported that organisational systems for recording compliments and comments were used to support quality improvements, they themselves and other authors of research studies have paid far more attention to complaints than to systems that record and analyse comments, compliments and other kinds of feedback. There appears to be little empirical research literature on for example how compliments and patients' commendations of staff are used in the management of services, about the impact of suggestion boxes and schemes, or about the ways in which litigation or threats of litigation are used in the management of services. Abbott et al. (2006) studied the role of Patient Advice and Liaison Services (PALS) in the NHS in England and reported that part of the role of PALS staff consisted of passing information from patients to staff so that staff could sort out problems and improve services. Similarly Evans et al. (2008) reported that the most frequent function of PALS was working with staff to resolve specific problems, but that many PALS services also had regular contact with and made recommendations to executive directors about services. The implication is that, although there has been little detailed research into how comments and suggestions are actually used, feedback generated through compliments and comments schemes and through patient liaison services may be a significant influence in the management of services.

Although Tasa et al. (1996) included patient focus groups as one of the methods of collecting patient feedback for quality improvement, the research literature on focus groups and patient involvement tends, in the UK at least, to be somewhat distinct from the literature on patient feedback. Although theoretical analyses of patient involvement (e.g. Bate and Robert 2006, Tritter and McCallum 2006, Tritter 2009, Fotaki 2011a) identify the provision of feedback and other kinds of information

by patients as part of a continuum or mosaic of involvement activities, systematic reviews of the research literature about public and patient involvement (e.g. Crawford et al. 2002, Daykin et al. 2007, Mockford et al. 2012) say very little about patient feedback or its impact on health services. Individual studies of patient involvement in the UK (e.g. Martin 2008, Attree et al. 2011, Armstrong et al. 2013) and other countries (e.g. Nathan et al. 2011) do however provide specific examples of patients who are members of focus groups or service development advisory groups providing feedback about the services they have used. This feedback is then used as part of the service planning or development initiative. Weinstein (2006) showed in more detail how feedback from patients that was obtained as part of a user-led quality improvement initiative in one community mental health centre in the UK had greater support from staff and users and was more actively used in the development and improvement of services than feedback obtained through an earlier professionally-led top-down initiative. The implication of these studies is that patient feedback is not always or necessarily separately identified as a distinct component of patient involvement activities; but feedback may be used more substantially and more effectively if it is an integral part of patient or user involvement in services.

Tasa et al. (1996) identified informal comments from patients to care givers and managers as one of the sources of feedback that was used to help improve the quality of services in the hospital they studied. Hudak et al. (2010) have drawn attention to the way in which compliments by patients to doctors may be attempts by the patient to influence the doctor's advice or decisions; they did not report on the ways in which doctors or other staff respond to or make use of compliments more generally. Despite these suggestions, the collection and use of feedback through these informal contacts between patients and clinical practitioners and managers appear to have been little studied in the empirical research literature. This again is a gap in the research literature.

In addition to the five main sources of patient feedback identified by Tasa et al. there has since about 2000 been a considerable expansion in the number of ways in which feedback has been collected and used in health services. These have included the collection of 'real-time' or near real-time feedback, at the bedside or in the clinic, often by electronic means, intended to facilitate the immediate identification and rectification of problems in the service (Brown et al. 2009). Brown et al. identified nine main methods of collecting real-time or near real-time feedback from patients: paper-based questionnaires, comment cards, and feedback forms; hand held electronic devices; electronic kiosks; bedside terminals; telephone interviewing; telephone helplines and comment lines; online questionnaires; websites and online

discussion communities; members' panels. The argument, summarised by Brown et al., is that the immediacy of this feedback and its relevance to individual wards or clinics mean that the feedback is much more likely to be used to help improve the quality of the service than are the results of a survey that become available only weeks or months after the events to which they relate.

Other recently developed methods of collecting feedback from patients include the use of 'mystery shoppers' and analysis of comments and posts in electronic social media – methods imported from other consumer industries in to health care (Greaves et al. 2014). Baraitser et al. (2008) for example reported on the use in one NHS sexual health service in England of patient volunteers as 'mystery shoppers' to help assess the quality of the service and identify opportunities for improvement. Levinson and Shojania (2011) have highlighted the importance of individual patients' stories in assessing the quality of and problems with services, arguing that the amount of detail and depth of understanding that can be obtained at an individual level is a necessary adjunct to broader picture that can be obtained from surveys or summaries of complaints. The argument here is that in depth feedback from the individual patient to individual service providers may engage the attention of staff and be a more powerful stimulus to improving the quality of services than an immediate one line answer or comment on an electronic device. The literature thus suggests a difference between depth and immediacy of feedback that may be reflected in both the contents of the feedback and how it is used in the management of services.

Despite (or perhaps because of) the lack of systematic analysis of different kinds of patient feedback based on empirical evidence, some commentators (e.g. Patwardhan and Patwardhan 2009, Coulter et al. 2009) have produced more comprehensive classifications. Coulter et al. stated that most acute trusts in the NHS collect a great deal of patient feedback in different ways, including national patient surveys, ward-level surveys, interviews and focus groups, patient forums, informal feedback to PALS, formal complaints, comments on websites (e.g. NHS Choices) and feedback on the performance of individual clinicians for appraisal or revalidation purposes. They identified (in their Appendix 2) 18 methods of providing feedback which they arranged in five broad groups.

- Surveys (postal surveys; interviewer administered face-to-face surveys; telephone surveys; interactive voice response / automated telephone surveys; on-line surveys; hand held portable devices; touch screen kiosks; bedside media consoles; routine statistics).
- In depth interviews (in depth interviews; discovery interviews).
- Group interviews (focus groups).

- Web-based feedback (web sites; comment cards, suggestion boxes and video boxes; complaints and compliments).
- Observational techniques (non-participant observation; participant observation; patient's diaries; mystery shopping; customer journey mapping).

Although this analysis identifies a considerable variety of different methods of collecting feedback, some of the classification is perhaps surprising; it is not clear for example why comment cards and suggestion boxes should be called web-based feedback or why patients' diaries are an observational technique. There is a lack of consistency in the classification. Their analysis does not include kinds of feedback (e.g. informal feedback through PALS, feedback for the appraisal of clinicians) that they mention elsewhere in their report. Equally important, the emphasis on measurement and tools may underplay the possibility of immediate, unstructured feedback from patients to doctors, nurses and managers. The classification of Coulter et al., like the classification of Tasa et al., contributes to the understanding and analysis of patient feedback, but is not a complete or consistent framework for analysis.

The increase in the last 15 years in the number and variety of ways of collecting feedback from patients has been accompanied by an increase in research studies examining the validity of and relationships between these different methods. The findings of these studies may have implications for the ways in which health service staff perceive and use feedback from patients. Studies reporting on the validity of surveys of hospital patients in different countries (Ocelli et al. 2013, Wong et al. 2013) or the validity of standard surveys of patients in individual hospital departments (Meehan et al. 2002, Bos et al. 2013, Sullivan et al. 2013) seem likely to increase the confidence of staff in the results of these surveys. Studies showing positive correlations between surveys of different aspects of hospital services (Raleigh et al. 2012), between different methods of collecting feedback from patients (Larsson 2006, Greaves et al. 2012) or between patient feedback and staff perceptions or measures of the quality of care (Jensen et al. 2011, Arah et al. 2013) are similarly likely to increase the confidence of staff in the results of the feedback. They are therefore likely, other things being equal, to strengthen and support the ways in which the feedback is used in the management of services. Although these studies provide no empirical evidence on the point, these correlations may also lead to the view that patient feedback about specific aspects of care may also be a useful indicator of the quality of services in a hospital more generally. Patient feedback may in these circumstances be used not only for the improvement of specific aspects of services but also as part of the assessment and assurance of services more generally.

The empirical research literature reviewed here contains no definitive or comprehensive classifications or analyses of the different kinds of patient feedback that are collected and used in the management of hospitals. But it does contain a considerable amount and variety of disparate information about different kinds of patient feedback, about different sources of feedback and different methods of collecting it. It suggests that national surveys may be used for comparative purposes to identify problems and local surveys to focus improvement activities; real-time and electronic feedback may be used to identify immediate operational problems and adjust the delivery of services; complaints and patients' stories to provide in-depth understanding of complex issues. What this empirical literature lacks, alongside the absence of any clear definition of feedback, is a systematic classification of different kinds of feedback, that then could then form the starting point for systematic analysis of the relationship between different kinds of feedback and different uses of feedback.

2.4 Domains of Patient Feedback

I have argued in the previous section that, despite a lack of systematic analysis and conceptual clarity in the published literature, different kinds of patient feedback are collected and used in the management of health services. The literature suggests that these different kinds of feedback may be used in different ways. A similar argument may be relevant to the different issues that are raised by patients in providing feedback – the domains of feedback. There are two questions to be addressed here: whether the different domains of feedback – clinical or non-clinical aspects of services, the attitudes and behaviour of doctors or clinic reception staff for example – are clearly defined and analysed in the literature; and whether feedback about these different domains is used in different ways in the provision and management of services. To address these questions, we need a conceptual analysis of the different domains of feedback, again not as an end in itself, but as a starting point for examining the different uses to which feedback is put.

Much of the existing material about the domains of feedback has to be extracted from empirical research literature about complaints and the descriptive literature about patient surveys, questionnaires, and interviews. Again it is a question of developing conceptual clarity that is fed by and contributes to the analysis of empirical data.

Much of the focus in the empirical research into patients' complaints has been on the identification of the issues that patients have complained about. A recent review by Reader et al. (2014) has drawn attention to the inconsistencies and gaps in the description and classification of complaints and has developed a systematic

taxonomy of complaints, grouping them into three broad domains – clinical, management and relationships – with categories and sub-categories within each domain, focusing for example in clinical quality on ‘quality of care’ or ‘treatment’ and in relationships on ‘communication breakdown’ or ‘staff attitude’. Many previous research studies have drawn data from the official organisational systems for recording complaints, using the classifications and records in those systems. Three studies in the UK (Hunt and Glucksman 1991, Ingram and Roy 1995, Siyambalapitiya et al. 2007) found that complaints are most frequently about medical or nursing aspects of the clinical care of patients, about staff attitudes, or about communication and information between staff and patients. Similarly studies in Australia (Anderson et al. 2000, Taylor et al. 2002, Parry and Hewage 2009) found that complaints related most frequently to treatment or other clinical issues, access and waiting times, or communication and staff attitudes. Montini et al. (2008) in the United States developed and tested a systematic taxonomy of patients’ complaints; they found that complaints related most frequently to unprofessional conduct (mainly the quality of interaction), poor provider-patient communication, treatment and care, and having to wait for care. With the exception of the study by Montini et al. each of these studies used data extracted from official systems about the nature of the complaint; they did not examine the basis of the recording and classification systems that identified the subject matter of the complaints. Thus it has often been difficult to identify from the literature the exact nature of the complaint, whether for example complaints about treatment and care are primarily about clinically inappropriate treatment or about the attitudes and behaviour of staff in providing the treatment and care.

Although all of these authors (and others who have undertaken similar studies in other countries) argue that information from complaints should be used to help improve the quality of services, they provide little information about whether or not it is in fact been so used. By way of exception, Taylor et al. (2002) in Australia found that that in less than 10 percent of complaints some kind of follow-up action was taken: a service or facility was provided; a policy or procedural change was made; staff were reprimanded or cautioned; or some other remedial action was taken. But Taylor et al. did not say whether different domains of complaints led to different kinds of actions. An indication of possible relationships is provided by Cunningham and Dovey (2006) who in a small scale in depth study in New Zealand reported individual cases where complaints about missed diagnosis, inappropriate treatment or ineffective treatment led to defensive changes by doctors in their medical practice. There is with these exceptions little information in the published research literature to show whether or

not information about the different issues raised by patients in complaints is used (or not used) in different ways in the management of services.

Information about the domains of patient feedback in the form of surveys, questionnaires and interviews can be identified from studies that report the results of the surveys or that examine the effectiveness of intervention based on specific kinds of patient feedback, as distinct from studies that have themselves directly examined the domains of feedback. Brooker and Dinshaw (1998) for example reported the results of a study, over a period of five years, to compare the views of patients and staff on a psychogeriatric assessment ward in one hospital in the UK about the quality of care on the ward and to describe the quality improvements made as a result of the comments. The interview schedule for patients was based on that used by the King's Fund in the 1970s and covered meals, physical environment, furniture, activities on the ward, patient choice, privacy, social interaction and the care provided. Naithani et al. (2006) used Freeman's model of the continuity of care to collect data from diabetes patients in one area of London about the continuity of care in terms of: regularity of consultations, tests and checks; communication with and trust and confidence in doctors and nurses; the ability to get advice and support when needed; and consistency of advice and support from different staff and services. Similarly Knowles et al. (2011) in examining patients' experience of the urgent and emergency care system in the UK reported patients' views about being able to access the right service, being given good advice, staff taking responsibility for sorting out the patient's problems, and continuity of care between different staff and agencies. Taken together these studies show that there is no simple listing or classification of the domains of patient feedback; individual surveys and questionnaires can and do focus on a variety of specific issues in specific services. Feedback may relate to almost any aspect of health care or the provision of health services. There is in the literature no underlying framework or consistency of analysis of the different domains of feedback collected through surveys of patients.

More detailed studies of specific aspects of individual services reveal a similar, complex picture. Evans et al. (2007) undertook a systematic literature review of instruments and feedback methods designed to assess patients' experiences with individual practising physicians, and to provide performance feedback at the individual level. The authors of each of the papers reviewed by Evans et al. had their own ways of identifying and defining the issues and aspects of physician activity and behaviour and service provision that the instruments focused on. Evans et al. said that Ramsay et al. and Grol et al. both used instruments that sought feedback on five key areas; but analysis of the summaries provided by Evans et al. shows that there is no clear

correspondence between the areas identified in the two studies. Ramsay et al. focused on access, technical competence, effective GP communication, GP interpersonal abilities, and the effective organisation of care; Grol et al. on relationships and communication, medical care, information and support, continuity and cooperation, facilities availability and accessibility. Common elements include access, communication, and interpersonal abilities and relations; differences include technical competence, the organisation of care, medical care, continuity and cooperation, and the availability of facilities. Even at this detailed level empirical research studies have not been based on a consistent, clear analysis of the domains of patient feedback.

A possible reason for this difficulty is suggested by the work of Entwistle et al. (2012). Entwistle et al. undertook a detailed qualitative study to identify the range of experiences of health care delivery that matter to patients and to develop a conceptual map of these experiences to help understand why they matter. They identified a large number of concepts relating to patient experience and mapped them on to World Health Organisation, Institute of Medicine and other widely used frameworks for quality. They then produced a conceptual map showing relationships between the characteristics of health care staff (e.g. staff are knowledgeable and competent; staff provide an appropriate environment for care; staff have integrity and are humane), the behaviour and actions of staff (e.g. staff respond to anxieties and concerns; staff explain and discuss things with the patients), and the ways in which these actions enable patients to be and do what they themselves value (e.g. getting help when they need it; being involved in decisions about their care; engaging in and contributing to meaningful daily life). The importance of this analysis, in addition to drawing attention to the complexity of patient experience and hence patient feedback, is its emphasis on the subjective nature of patient experience and on the immediate interaction between patients and staff. Patient experience in these terms is not only about the appropriateness and effectiveness of diagnosis and treatment; it is also about the feelings and experience of patients and about relationships between doctors, nurses, other staff and patients. One implication for the study of the use of patient feedback, although this is not spelled out by Entwistle et al., is that feedback about health care is feedback about staff. Feedback may therefore potentially be used most immediately to influence the attitudes and actions of staff; an issue that forms the starting point of my second subsidiary research question.

The research of Entwistle et al. along with studies by other authors raises the question of the relative importance of different domains of patient feedback: how do different domains of feedback relate to each other; what matters to patients; what

matters to staff (Black et al. 2014, Keller et al. 2014)? Although Entwistle et al. used workshops consisting of patient advocates, government policy officers and researchers to help generate their conceptual map, they did not distinguish between the views of patients and others. Konteh et al. (2011) studied the similarities and differences between the views of clinical governance leads and patient representatives about the importance of various cultural attributes for high quality health care in English NHS trusts. They found that the governance leads and patient representatives agreed that patient centredness, a quality focus, senior management commitment, safety awareness and team working were very important, but that more governance leads than patient representatives thought a blame-free culture very important and that more patient representatives than governance leads thought customised care very important. The results of Konteh et al. as a whole suggest a substantial degree of agreement between clinical governance leads and patient representatives about the importance or relative lack of importance of different aspects of the quality of services. If this agreement extends to other managers in hospitals, it is likely that staff and patients would also agree more generally about the importance of particular issues or domains of patient feedback and that feedback about those issues would be more likely than feedback about other issues to be used to help improve services.

The complexity of the subjective and objective domains of patient experience and patient feedback identified in the empirical research leaves us with questions about the ways in which this feedback can be conceptualised and with questions about whether feedback about different domains is used in different ways in the management of services. Coulter et al. (2009, page 8) stated that in England 'national surveys include fairly detailed questions on most aspects of patients' experience': choice of provider; access and waiting times; confidence and trust in health professionals; information and communication; involvement in treatment decisions; availability of staff when needed; hygiene, cleanliness and hand-washing; food and physical environment; access to records and medical communications; being treated with dignity and respect; and overall satisfaction. What is notable about this list is that although the national surveys in England ask about many aspects of patient experience, they do not ask about issues that are central to the delivery of health care and are prominent sources of complaints by patients: clinical investigation, diagnosis and treatment and the quality of care and after-care (Reader et al. 2014). And, although the surveys ask about information and communication and about being treated with dignity and respect, they do not ask directly about staff attitudes and behaviour, the general quality of interaction between staff and patient, the aspects of

patient experience highlighted in complaints and in the research of Evans et al. (2007) and Entwistle et al. (2012).

The increasing focus over the last 10 years on the safety of health care has been accompanied by a growth in the number of research studies examining the potential contribution of patient feedback and other kinds of information provided by patients to the safety of services. Recent research has examined the question of whether or not patients are able to provide feedback on safety-related issues. Giles et al. (2013) in England found that patients were able to comment on 13 of the 20 domains in the Yorkshire Contributory Factors Framework – an analytical tool developed by the Yorkshire and Humberside Improvement Academy for investigating patient safety incidents – including for example communication, the physical environment, scheduling and bed management, dignity and respect, and lines of responsibility. Other studies suggest that patients can and do provide feedback that could be used to improve safety. McDonald et al. (2013) in a review of the research literature about the involvement of patients in strategies to mitigate diagnostic errors argued that a very low proportion of diagnostic errors reported in feedback from patients had been detected and reported by hospitals' own internal systems. They argued that reporting of diagnostic errors by patients would help physicians improve their own practice and would help health care organisations develop their systems. Research has also focused on the question of whether patient involvement strategies influence the willingness of patients to be involved in safety issues and the extent to which, as part of these strategies, patients do provide feedback or other information to clinical staff or managers. Berger et al. (2013) argued that there is very limited evidence of the effectiveness of these strategies in influencing patients' behaviour and actions, relating for example to hand hygiene, other health care related infections and the use of surgical checklists. The implication is that, if these interventions do not have a substantial influence on the actions of patients, then there will be little subsequent effect on the ways in which the feedback from patients is actually used in the management and provision of services. The studies of the potential use of feedback to improve the safety of services, like the earlier studies of patients' complaints, focus much more on how the feedback from patients could be used to improve the safety of services than on how it is actually used.

The literature reviewed here shows that patient feedback relates to many different aspects of treatment and care, staff attitudes and behaviour and the delivery of services. There are many different domains of feedback. The literature at this stage of analysis also perhaps suggests that feedback about different domains of patient experience is used in different ways for different purposes. Feedback about

diagnosis and treatment is used primarily by clinical practitioners in the management of their own clinical practice (Allsop and Mulcahy 1998, Cunningham and Dovey 2006). Feedback about access and service delivery is used by general managers in the delivery and development of services (Tasa et al. 1996, Reeves and Seccombe 2008). There is very substantial evidence in the literature that many complaints and critical feedback in surveys are about staff attitudes, behaviour and communication (Montini et al. 2008, Reader et al. 2014). But, despite the findings of Davies and Cleary (2005) that managers put on training course to improve 'customer care' and develop the interpersonal skills of reception staff, there is very little evidence in the literature about how this feedback is used in the management and motivation of staff to improve the quality of services they provide for patients. This is a significant gap in the research literature which I will aim to address as part of this study.

The classification of the domains of feedback is important because there is some evidence to suggest that there are positive relationships between different aspects of patient experience and the clinical quality of care. Levinson and Shojania (2011) have argued that there are close links between the technical and patient-centred aspects of medical and health care. Black et al. (2014) have reported associations between patient reported experience and patient reported outcome measures. Keller et al. (2014) have reported positive relationships between patients' ratings of the quality of care and communication and their overall satisfaction with services. Research in the UK has shown that there are consistent relationships between the performance of hospitals as assessed in national patient surveys and the national staff survey in the NHS (Raleigh et al. 2009) and that some hospitals consistently perform better than others across all aspects of patient experience (Raleigh et al. 2012). The implication of all these studies is that feedback about one domain of patient experience or services is likely to be positively related to feedback about other domains. It is important to examine the collection and use of feedback not only about the individual domains of patient experience but about patient experience and the quality of services as a whole. Feedback about one aspect of a service may be used to help assess and assure the quality of that service as a whole.

To say that feedback about these different domains may be used in the management of services is not of course to argue that it always is about these domains or that it is always used to improve services or for other purposes. There are substantial gaps in the research literature about the extent to which feedback about the appropriateness and effectiveness of diagnosis and treatment is collected and used in the management of services. There is little data about the ways in which feedback about staff attitudes and behaviour is used in the motivation and

management of staff, as distinct from its use in the management of services more generally. There is little data about the ways in which feedback about patients' subjective experience of services (as distinct from feedback about services themselves) is used in the management of services. The gaps in the literature are not only empirical but also conceptual; there is no clear, well-established framework for identifying and analysing the different domains of patient feedback that can serve as the basis for examining how the different kinds of feedback are used.

2.5 The Use of Patient Feedback: 'Improvement'

I have argued in the previous sections of this chapter that a variety of different kinds of patient feedback about a variety of different domains of patients' experience of health care are collected and used in the management of health services in the NHS in England, but that there is little systematic analysis and evidence about the different uses to which these different kinds and domains of feedback are put. I argued in Chapter 1 that managers and policy makers in the NHS often assume that the aim of collecting feedback is in some way to improve services. The NHS Patient Feedback Challenge, launched in March 2012, aimed for example to 'develop and spread good and innovative practice for using patient feedback to improve healthcare services.' (NHS Institute for Innovation and Improvement 2013). My initial reading of the research literature supported my view that many researchers, as well as practitioners and policy-makers, adopted the implicit view that the purpose of collecting feedback was to improve services. In this section I therefore review the research literature to examine this assumption that the purpose of feedback is to improve services. In doing this I focus on two sets of literature: empirical research literature about the use of patient feedback to improve health care or health services; and a wider set of literature about improvement in health and other public services. My aim is to develop an analytical framework for examining in depth empirical data about how patient feedback is or is not used to help improve services; what we mean when we say that the aim of using patient feedback is to 'improve' services.

Spencer (1996) commented that earlier studies of patient satisfaction had all too often simply reported patients' views about services but had not been followed by action to improve the services. Much of the research literature assumes explicitly or implicitly like Spencer that the purpose of patient feedback is to improve services for patients. But different authors emphasise different aspects of the services that are to be improved: improving clinical care (Bark et al. 1994, Jorde and Nordoy 1999); improving quality (Tasa et al. 1996, Davies and Cleary 2005, Reeves and Seccombe 2008, Locock et al. 2014); improving safety (Jonsson and Ovretveit 2008); improving

the skills of staff (Greco et al. 2001, Cheraghi-Sohi and Bower 2008); improving services (Patel et al. 2007, Patwardhan and Patwardhan (2009); improving patient satisfaction (Hsieh 2009, Rozenblum et al. 2013); and improving patient experience (Raleigh et al. 2009, 2012). Although the focus in these papers is on improving of services for patients, they offer very little systematic analysis of what is meant by improvement. Some simply equate patient satisfaction or patients' ratings of services with improvement; others give examples of changes in services and simply label them as improvements. I am not arguing here that 'improvements' such as increases in patient satisfaction or shorter waiting times, more attentive staff or cleaner hospitals are not in fact improvements; I am simply making the point that there is in the empirical research literature about patient feedback little analysis about the nature of improvement or the standards by which improvement is assessed and evaluated. This is a significant conceptual gap in the empirical research literature about patient feedback.

The research literature suggests that feedback from patients is primarily used in specific service improvement initiatives in hospitals and other health services. Draper et al. (2001) reported that a survey of women who had recently had babies in one Australian state was used to inform the development, implementation and evaluation of government policies and service development at hospital level. Davies et al. (2008) reported that all medical groups in their study in the US had used patient survey data to improve patient-centred care. Boyer et al. (2006) reported that almost half the clinical staff they surveyed in one large French hospital said that feedback had led to service improvement projects. Reeves and Seccombe (2008) reported that nearly all their respondents in acute NHS trusts in England said that the results of the national in-patient survey had been used as the basis of action plans aimed at improving the quality of care and for measuring the success of these plans. The literature suggests, without being very clear about the detailed processes involved, that patient surveys are used to help initiate or support the implementation of improvement projects. In so far as these studies describe how feedback is used, they tend to refer to formal management 'action plans' for improvement.

There is a scattered literature from the UK, the USA, Australia and other countries identifying in more detail specific changes and improvements in hospital services that have resulted from local or national surveys of patients' views. Surveys have led for example to improvements in access, decreasing waiting times for appointments, scheduling appointments with patients' preferred doctor, the development of protocols for the arrival of patients at a service, improving reception skills, training front of house staff in customer relations, the development of

information sheets and educational material for patients, the integration of care, improvements in communication and interpersonal care, food services, the physical environment, noise at night, the organisation of discharge from hospital, discharge information packs and the provision of information about discharge and medication (Draper et al. 2001, Davies and Cleary 2005, Boyer et al. 2006, Reeves and Seccombe 2008, Davies et al. 2008). These studies of the results of patient surveys identify changes and improvements relating most frequently to administrative and hotel and support services in hospital, to access, admission and reception, and to information and support at the time of discharge. The studies usually contain little detail about the exact nature of the changes and improvements. They do not identify changes relating directly to the quality or safety of treatment and care in clinical services. Nor do they draw a clear distinction between improving the quality of health care, improving the quality of health services, and improving or developing services per se. They do not identify the criteria and standards by which improvements are identified and evaluated as improvements. They do not examine systematically what is meant by 'improvement'. This is a weakness in the empirical patient feedback in the research literature that I will consider again later in this section and that will then form the starting point of my first subsidiary research question.

Despite the argument of Bark et al. (1994) and others (e.g. Anderson et al. 2000, Montini et al. 2008) that patients' complaints and other kinds of feedback should be used to improve the quality of clinical care, there have been very few studies that have examined the actual use of complaints or other kinds of patient feedback directly to improve clinical care. As already noted Taylor et al. (2002) in Australia reported that about 10 percent of complaints resulted in some kind of follow-up action; but Taylor et al. provided no clear information about the issues raised or actions taken. Jorde and Nordoy (1999) found that feeding back to clinical staff in hospital the results of an analysis of hospital records and of a patient survey resulted in statistically significant increases in the recording in the hospital record and discharge letters of information about the patient's occupation, smoking and alcohol consumption, general physical health and the prescribed drugs to be used by the patient. They also found an increase in the proportion of patients who rated the behaviour of doctors as excellent. Although this paper suggests that feedback from patients may influence the clinical care provided by doctors, the fact that Jorde and Nordoy included two interventions – feedback about their analysis of case records and feedback about feedback from patients – in their study means that it is impossible to identify direct effects of the patient feedback on the recording of clinical information. The results do

however suggest that feedback from patients may have influenced the behaviour of the doctors with the patients.

Despite the frequency of patient feedback and complaints about the attitude and behaviour of staff, there has been little research that has examined the ways in which this feedback has been used to change staff attitudes and improve behaviour. Some studies (e.g. Davies and Cleary 2005, Boyer et al. 2006) have reported that surveys have been used to train reception staff in customer relations skills. A small group of intervention studies (discussed below) has focused on the use of patient feedback to improve the communication and interpersonal skills of doctors. But there appears to be little research that has examined the use of feedback to influence the attitudes and behaviour of clinical and non-clinical staff more generally. This is a significant gap in the published research literature that leads directly to my second subsidiary research question: 'How do managers in hospitals use patient feedback to influence and manage the staff who provide services for patients?'

Evans et al. (2007) in a systematic literature review summarised six studies that had examined survey instruments for collecting feedback from patients about one aspect of clinical care, the interpersonal skills and behaviour of doctors in interaction with patients. The results of the surveys were fed back to doctors in a variety of ways, as summary results to the practice or as detailed results for the individual doctors with or without interpretive analysis and suggestions that the results should be discussed with mentors or colleagues. Only two of the six studies reported on the effects of the feedback on doctors' skills and behaviour. Wensing et al. (1998, 2003) in a study of fully qualified GPs in the Netherlands found that, despite a range of reported actions (including discussing the results with colleagues, participating in continuing education, and changing practice routines and organisation), the feedback had no effect on patients' ratings of the doctors' behaviour. Greco et al. (2001) in a study of GP trainees in England found individual feedback of patients' evaluation of trainees' behaviour with benchmarking information in the early stages of training was used by trainees as a way of learning and attempting to modify their behaviour with patients; it resulted in improvements in patients' assessment of the doctors' behaviour. These findings suggest that the ways in patient feedback is used by doctors to influence their practice (e.g. to support learning and changes in their personal behaviour) is in some ways consistent between settings, but that the effects of the feedback on the doctors' behaviour (as assessed by patients) depend substantially on the initial circumstances of the doctors' interaction with patients.

The empirical research literature about the use of patient feedback that I have reviewed here supports the view that patient feedback is in fact used primarily with

the aim of improving services for patients. But there is little clarity or consistency of analysis in the literature about which aspects of the quality or provision of services are to be improved or about how improvement is to be assessed or measured. There is research evidence to show that surveys are used to help improve patients' access to services, communication between staff and patients and the attitudes and behaviour of staff, the organisation and delivery of care, and hotel and support services. But the evidence in terms of the number and depth of studies is limited. And the research relates exclusively to surveys of patients; it says nothing about how other kinds of feedback are used to improve services. There is a substantial gap in the empirical research literature relating to the use of the variety of different kinds of patient feedback other than surveys to improve services. It is one of the aims of the present study to help fill this gap by collecting data about the use of different kinds of patient feedback to improve hospital services; this leads directly to my first subsidiary research question: 'In what ways are different kinds of patient feedback used to improve hospital services?'

As important as the gaps in empirical research findings is the fact that the conceptual underpinnings of the research reviewed here are not fully articulated in the published research papers. The studies do not systematically analyse or classify the use of feedback to improve services; they simply give examples of improvement resulting from feedback. At the same time, these studies do not, as argued in this section, develop or use a clear analytical framework about the broader aspects of health care or health services that are being improved. In order to help address this weakness I now draw on a wider research literature about the nature of improvement in health care and health services. My focus here is not so much on the methods by which improvements may be achieved (as examined in for example the reviews of the Health Foundation 2011, Dixon-Woods et al. 2012, Marshall et al. 2013, and Braithwaite et al. 2014 drawing on the improvement science literature more generally), as on the actual nature of improvement itself, the criteria and standards by which improvement in health services is identified and assessed.

Part of the impetus for improvement in health services came from the work in the 1980s of Donald Berwick, then at the Harvard Community Health Plan. Berwick (1989), drawing on the experience of Japanese manufacturing industry and earlier American research, applied the theory of continuous quality improvement to health care. He argued that detailed analysis of processes, focusing on the average producer not the outliers, and on continuous effort to reduce waste, rework and complexity would result in continuous improvement in quality. In this analysis Berwick identified 'problems' in terms of poor design, unclear purpose and failures of

leadership; he did not explicitly define 'improvement' but his comments on waste and rework imply that despite his use of the word 'quality' he was also thinking of improvement in terms of greater efficiency – producing a given level of output with less resources. The emphasis on efficiency, the use of resources and organisational processes, without explicit definition of the nature of improvement, is also identifiable in some of Berwick's (1998) later work and, to some extent, in the UK health service improvement science literature mentioned above.

One of the persistent themes of the patient feedback literature is that feedback is and should be used to help improve the quality of health care or health services. There is an enormous research and practice literature, in health services and other organisations, about quality. This literature includes a variety of conceptual frameworks setting out different characteristics of health care that are considered to comprise the quality of services. Following earlier work by for example Donabedian (1980) in the United States and Maxwell (1984) in the United Kingdom that included the social functioning and context of health services, the Institute of Medicine (2001) outlined principles for a new health system for the USA in the 21st century. The IoM outlined a broad purpose: 'to continually reduce the burden of illness, injury, and disability, and to improve the health and functioning of the people of the United States.' that would lead to a shared vision of six specific aims for improvement, built around the core need for health care to be:

- safe: avoiding injuries to patients from the care that is intended to help them;
- effective: providing services based on scientific knowledge to all who could benefit, and refraining from providing services to those not likely to benefit;
- patient-centred: providing care that is respectful of and responsive to individual patient preferences, needs, and values, and ensuring that patient values guide all clinical decisions;
- timely: reducing waits and sometimes harmful delays for both those who receive and those who give care;
- efficient: avoiding waste, including waste of equipment, supplies, ideas, and energy;
- equitable: providing care that does not vary in quality because of personal characteristics such as gender, ethnicity, geographic location, and socioeconomic status.

This framework and other similar analyses of quality can be argued to relate to two different aspects of health care. Notions of being safe, patient-centred and timely relate quite simply and directly to the quality of individual episodes of health care; but effective, efficient and equitable are to some extent different. Effectiveness and equity

are definable in terms of the relationships between health care and the health needs of the people or population for whom the care is provided; efficiency is defined in terms of the relationship between the services that are provided (outputs) and the resources (inputs) that are used to provide them. In both cases however the notion of improvement, which is the core of the IoM's analysis, is based on judgements about what constitutes good quality: safety is a positive attribute, causing injury to patients a negative one; efficiency is a positive attribute, waste a negative one. In these terms, although the criteria and standards are implicit rather than explicit, an improvement is a change that results in better quality.

Similarly a view, supported by the World Health Organization (Valentine et al. 2003), of the quality of health services suggested that the responsiveness of health care systems should be identified in terms of specific attributes of health care, without analysis of the principles underlying the identification and analysis of those attributes. It focused on the autonomy of patients and families, choice of health care providers, clarity of communication, confidentiality of personal information, dignity, prompt attention, quality of basic amenities and access to family and community support. It should be noted here that the focus on responsiveness means that this is not a comprehensive analysis of the domains of the quality of health care and hence of 'improvement'. It says nothing about the appropriateness, effectiveness, equity or efficiency of health services. It says little about the attitudes and behaviour of staff, about 'patient-centredness' or about the organisational processes that may promote or hinder improvements in health services. In this way the WHO schema identifies responsiveness as one, but only one, aspect of quality.

Boyne (2003) unlike Berwick did offer a formal definition of 'improvement'. He argued that at that time there were no academic definitions of public service improvement, but that the large organisational effectiveness literature contained a variety of conceptual models that could lead towards a definition of improvement. Following a review of five models (the goal model, the systems-resources model, the internal process model, the competing values model, and the multiple constituencies model) of improvement, he argued that elements of the goal model (emphasising the formal but potentially changing purposes for which organisations are established) and the multiple constituencies model (emphasising the complexities that arise when different groups of people use different criteria to assess the effectiveness of organisations) together led to a formal but provisional definition of public service improvement as 'a closer correspondence between perceptions of actual and desired standards of service.' This definition is important because it introduces the notion of explicit standards of service; it also draws a distinction between actual standards and

desired standards. But the definition of improvement as a closer correspondence between actual and desired standards leads as Boyne himself recognised to the implication that, if desired standards are lower than current standards, a reduction in actual performance or quality is by definition an improvement.

Despite being quoted in the subsequent public service improvement literature Boyne's definition of improvement has not been the starting point for major programmes of empirical investigation. Talbot (2010) examined theories of performance that underpin organisational and service improvement in the public domain. Drawing on policy analysis and literature, Talbot analyses performance, and hence by implications improvement or deterioration in performance, in terms of three basic concepts: inputs, outputs and outcomes. He notes that each area can further be analysed in terms of quantity, quality and satisfaction. Inputs are defined as the resources used to produce outputs; outputs are the goods and services produced by an organisation; outcomes are the impact of the outputs (or service) on the people using the service or the community or public more widely. 'Improvements' in this analysis are changes that result in more or better quality outputs or outcomes.

Boyne et al. (2010) follow Boyne (2003) in defining public service improvement as a closer correspondence between perceptions of actual and desired standards of public services, and comment (page 3) that 'unfortunately the measurement of 'actual and desired' standards is far from straightforward.' They identify three approaches in the literature to the measurement of standards:

- the outcome or goal attainment model, with outcomes framed in terms of specific policy objectives and interventions;
- the measurement of service outputs e.g. the quantity, quality or efficiency of a service; and
- the focus on the processes and practices used to produce outputs, 'doing things right'.

Chapters two to ten of the Boyne et al.'s book then contain reviews of empirical research studies of different influences (e.g. regulation, leadership, organisational culture, human resource management, organisational learning) on performance in public services in the UK, the USA and other countries. The analysis of performance is presented in terms of outcomes, outputs, processes or a mixture of the three. Although the small number and wide range of studies reviewed in the book about influences on the performance of health services in the UK mean that it is very difficult to draw substantial conclusions about the influence of different factors on performance in this sector, and although there is little detail about the specific measures used in individual studies, it is the inclusion of measures of process as a

distinct aspect of performance that is important here. Process, what happens inside an organisation and results in the production of outputs, is alongside outputs and outcomes a significant aspect of performance and hence of improvement.

There are substantial similarities but also some differences between the frameworks of 'improvement' outlined by Talbot and Boyne et al. Both focus on outputs, defined as the services produced by organisations and delivered to the people who use them. Both focus on outcomes, but define them rather differently: Talbot defines outcomes as the impact of services on the people who use them or on the public more widely; Boyne et al. define outcomes in terms of the achievement (or not) of specific policy objectives or interventions. But whereas Talbot also includes inputs (resources) in his framework, Boyne et al. do not and instead include processes and practices used to produce outputs. Although there is some overlap between resources and processes, it may also be useful to maintain a degree of difference between them, leading to a potential framework for analysis of improvement that consists of inputs, processes, outputs and outcomes.

Drawing these various analyses together, it can be suggested that improvements in health services can be examined initially (following Talbot 2010) in terms of inputs, outputs and outcomes, and that inputs, outputs and outcomes can be assessed in terms of quantity, quality and satisfaction. Organisational processes contribute to the production of outputs and outcomes, and hence to improvements in services. What Berwick, the Institute of Medicine and other authors bring to this abstract framework is partly some general categories (e.g. efficiency, outcomes) and more concretely a wide variety of specific ideas about what constitutes good quality in health care and health services (e.g. quick access, safety, appropriate advice, good communication). These ideas about quality, and hence about improvement, are underpinned by criteria that often are not explicitly identified by practitioners or commentators. The ideas about improvement are based on criteria and standards (often implicit rather than explicit) for identifying something as a problem, a success or an improvement. One of the aims of the present study is to draw on this wider conceptual literature to help identify and analyse the standards and criteria that underpin the actual use of feedback to improve services.

The analysis so far is expressed in 'objective' terms of what happens in health services. Satisfaction is something different; patient satisfaction is self-evidently one aspect of the subjective experience of people who use services. 'Patient experience' following Entwistle et al. (2012) has a substantial component of subjectivity; but the phrase 'patient experience' may also be used to refer to patients' observation and reports of services 'as they really are'. The introduction of terms like satisfaction and

patient experience into discussions of improvement in health services therefore mean that improvement must be analysed (following Boyne 2003) not only in terms of objective measures but also in terms of the subjective perceptions and experiences of people who use services.

This literature thus provides a framework for looking more systematically for answers to my first subsidiary research question 'in what ways is patient feedback used to improve hospital services?' The analysis suggests that the potential use of feedback should be sought in terms of a conceptual framework built around inputs, process, outputs and outcomes, in terms of quantity and quality, and in terms of patient satisfaction and patient experience. The internal processes and external relationships of organisations may have a substantial effect on the ways in feedback is used. The use of patient feedback to stimulate or support specific service improvements should be not only described in empirical terms; it should also be analysed in terms of the criteria, standards and measurements that underpin and inform the actions that managers take in using that feedback. I will use this conceptual framework (focusing on inputs, processes and outcomes, on quality and quantity, on the domains of service, patient satisfaction and patient experience, and on criteria, standards and measurement of improvement) to help develop and support in the later chapters of this thesis the empirical analysis of my data.

2.6 Beyond Improvement: Additional Uses of Patient Feedback

In the previous two sections I have argued that the patient feedback research literature presents improvement as the main goal of collecting and using patient feedback, but contains little systematic analysis of what is meant by improvement or how improvement should be measured. In this section I review the research literature about the ways in which patient feedback is used in organisational processes that support the improvement of services. I also review the literature about the uses of feedback that are in themselves not simply about improvement but extend into other areas of service provision and management. My focus here is not only on the different uses of feedback as they are identified in the empirical literature and commentaries, but also on the conceptual underpinnings of these different uses and on their relationships with the improvement of services.

Tasa et al. (1996) is the only study reviewed here that has explicitly identified and listed different ways in which patient feedback is used to improve the quality of services in hospital. Tasa et al. focused not so much on the aims of using feedback as on the processes through which it is used; they identified six main uses of patient feedback in the hospital where they undertook their research.

- Dissemination.
- Strategic and annual planning.
- Identifying broad issues.
- Responding to immediate problems.
- Selecting quality improvement teams.
- Monitoring process requirements and changes.

What is especially important in the work of Tasa et al. – issues that have not on the whole been taken up in subsequent empirical research reporting the use of patient feedback in specific improvement initiatives – is their focus on the links between patient feedback and broader organisational processes, the use of patient feedback in strategic and annual planning, setting priorities for improvement, and monitoring changes. The use of patient feedback in the governance, planning and performance management of hospital services is an important issue that has not been the primary subject of subsequent empirical research. But, despite their analysis of different kinds of feedback and different uses made of that feedback, Tasa et al. did not (with the exception of noting that complaints were used to identify and deal with immediate problems) say whether different kinds of feedback were used in different ways in the hospital they studied.

The empirical literature suggests that there is considerable variability in the extent to which and ways in which the results of patient feedback are disseminated within hospitals. The results of national surveys of hospital patients in the UK are communicated to patients and the public through posters and leaflets in public areas, press releases, annual reports, presentations to patient and public involvement groups, and articles in trust magazines; results are communicated to staff through trust intranets, newsletters, meetings with presentations by contractors, teaching sessions, and forward planning meetings (Reeves and Seccombe 2008). Results are presented and discussed at service and ward level meetings in hospitals and, where relevant, with individual members of staff (Davies and Cleary 2005, Boyer et al 2006, Davies et al. 2008). Results (in full or in summary) are sometimes but not always presented to boards of directors. Boards review the data, but it is not clear from the literature what decisions boards or other managers make using the feedback. Nor is it clear what else boards and managers do as a result of the dissemination of the feedback (Davies and Cleary 2005, Reeves and Seccombe 2008).

In saying that feedback is used as the basis for service improvement, the literature does not claim that feedback on its own is a sufficient condition for action to improve services. In a broader context feedback may be used to inform research and policy that themselves may influence the provision and management of services

locally (Ziebland and Hunt 2014). Within individual hospitals local factors are important. Boyer et al. (2006) for example stated that results of patient satisfaction surveys in the French hospital they studied were insufficiently disseminated by ward managers and insufficiently discussed within the teams to develop an improvement programme; only a few department teams planned specific actions to improve the quality of care. Similarly Davies et al. (2008) reported that six of the eight quality improvement initiative leads in their study mounted interventions on the basis of survey results, but that two got no further than looking at the data or setting goals; of the six, four implemented their interventions as originally planned. Reeves and Seccombe (2008) noted that the results of surveys are not in themselves always sufficient for people to take action; people need direction to make them do things and frameworks to help them. They also noted that the implementation of action plans was sometimes part of the formal performance assessment of some individuals. Tasa et al. (1996) highlighted the use of patient feedback in strategic and annual planning, identifying broad issues and monitoring changes. Taken together these findings suggest that formal organisational processes of planning, review and performance management may be significant contributors to the consistent use of patient feedback to improve the quality of services.

The literature identifies a variety of factors that support or impede the use of feedback in this way. Two research studies (Davies and Cleary 2005, Reeves and Seccombe 2008), one systematic literature review (Daykin et al. 2007) and two policy-orientated reviews written for the NHS in England (Boaden et al. 2008, Brown et al. 2009) list factors that contribute to or inhibit the success of the various initiatives in which they were interested. The major factors that influence the use of feedback appear from this literature to be: top management support and inputs; attitudes and commitment of clinical professions (especially doctors); organisational culture: patient-centred and supporting change; external environment: regulations, targets, incentives and performance monitoring; competing organisational priorities; the costs and effectiveness of feedback and quality interventions; formal feedback and quality improvement strategies, processes, resources, and infrastructure; the resources and skills available for collecting, analysing and using feedback and for changing services; detailed, specific and timely data collected through robust methods, analysed and presented clearly and appropriately; and dissemination of information to individuals and teams accompanied by appropriate additional action. The published literature thus suggests something of the organisational and managerial processes influencing the use of patient feedback, both at a senior management and board level within hospitals and in terms of the reactions and responses of doctors and other clinical

staff. These processes are potentially an integral part of the answer to the question of 'how' patient feedback is used in the management of services.

Coulter et al. (2009) identified 11 objectives for the collection and use of feedback from patients. These objectives can be collated into three main groups.

- The internal management of hospitals or other health services: understanding current problems in care delivery; informing continuous improvement and redesign of services; helping professionals reflect on their own and their team's practice; and monitoring the impact of any changes.
- Benchmarking or comparison of services: facilitating benchmarking between services/organisations; and comparing organisations for performance assessment purposes.
- Providing information to patients, referrers, commissioners or the public: informing referring clinicians about the quality of services; informing commissioners and patients about the quality of services; informing patients about care pathways; helping patients choose high quality providers; enabling public accountability.

The research literature I have reviewed in this chapter suggests that empirical study of the use of patient feedback has focused almost entirely on the first of these areas, the use of feedback inside hospitals and other health service organisations to help improve services. There has been little or no research examining whether and how feedback is used in the benchmarking and comparison of services or in making information available to patients, referrers and other organisations.

This research literature and the studies of Davies et al. (2008) and Reeves and Secombe (2008) suggest that there is a close relationship between the organisational processes through which feedback from patients is used in the management of health services and the actual ways and extent to which it is used. Feedback may be used to help establish service strategies and annual plans; it may be used to monitor and help assure the quality and safety of services. Strategies and plans, monitoring and assurance are all part of the responsibilities of senior managers and directors in NHS Trusts. The literature shows that extent to which feedback is or is not used in the management of services is influenced by the attitudes and actions of the directors and chief executives of Trusts. But the literature does not itself directly report what executive directors or boards of directors themselves actually do with feedback from patients: do they use it to initiate service improvements and strategies; do they use it to monitor and assess the impact of their decisions and initiatives; do they use it to assess and assure the quality of services; do they themselves use it all? This is a substantial gap in the empirical research literature about the use of patient

feedback; it is only by understanding what senior managers in individual Trusts do with patient feedback that we can have a full picture of how feedback is used in that Trust as a whole. This is a gap in the literature leading to my third subsidiary research question: 'How do Boards of Directors of NHS Trusts themselves use patient feedback in the management of hospital services?'

2.7 Research Questions

In Chapter 1 and Chapter 2 of this thesis I have argued that policy, practice and empirical research about feedback from patients in the NHS in England and in health care in other countries have focused more on the collection than on the use of feedback. Despite the ground-breaking study of Tasa et al. (1996) in one United States hospital there has been very little systematic research, in the United States, the United Kingdom or other countries, into the ways in which all kinds of patient feedback are used in the management of hospitals. This is a substantial gap in the research literature relating to the use of patient feedback. The primary question being addressed in this research is therefore: 'How is feedback from patients used, or not used, in the management of hospitals in the NHS in England?'

In Section 2.5 of this chapter I have argued that the research literature indicates that patient feedback is used primarily to help improve health services, but that there is little systematic analysis of what is meant by improvement. The empirical patient feedback literature provides many examples of different kinds of feedback being used to improve different aspects of health care or health services but does not identify explicit criteria or standards of improvement. This is a significant weakness in the empirical patient feedback research literature. The wider literature about patient experience (e.g. Entwistle et al. 2012) draws a useful distinction between the subjective and objective aspects of patients' experience that may be the focus of improvement initiatives; the public service improvement literature (e.g. Talbot 2010, Boyne et al. 2010) provide a framework in terms of inputs, processes, outputs and outcomes that also can be used to help analyse the ways in which the use of patient feedback to improve services can be analysed. The gaps in the empirical patient feedback research literature and the frameworks suggested by the wider patient experience and public service literatures lead to my first subsidiary research question: 'In what ways are different kinds of patient feedback used to improve hospital services?'

In Section 2.4 of this chapter I showed that a great deal of feedback from patients is about the attitudes and behaviour of the staff who provide health care; it is about the ways in which staff do or do not communicate effectively with patients and

about the ways in which staff provide treatment and care. Health care is for the most part provided by doctors, nurses, therapists and a whole range of other staff. I also argued in Section 2.4 that the analysis by Entwistle et al (2012) of patient experience in terms of the characteristics, behaviours and actions of staff emphasises the importance of the relationships between clinical and non-clinical staff and patients. But, despite these findings and analyses, there has been very little empirical research that has examined the ways in which patient feedback is used to influence and manage staff. The main findings of for example Davies and Cleary (2005) and Boyer et al (2006) relate to the use of surveys to train reception staff in customer relations skills; there is no research literature on other uses of feedback with other groups of staff. This is a substantial gap in the literature, leading to my second subsidiary research question: 'How do managers in hospitals use patient feedback to influence and manage the staff who provide services for patients?'

In Section 2.6 of this chapter I argued that Tasa et al. (1996) had undertaken one of the few studies that reported directly on a range of organisational processes through which managers and others in hospitals made use of patient feedback. Other studies (e.g. Davies and Cleary 2005, Davies et al. 2008, Reeves and Seccombe 2008) have reported in more detail on the ways in which the results of feedback are disseminated in hospitals and discussed with staff. Results of surveys are sometimes but not always presented to boards of directors. But, despite the fact that a variety of research studies (e.g. Davies and Cleary 2005, Reeves and Seccombe 2008) and policy-orientated reviews (Boaden et al. 2008, Brown et al. 2009) report that the support of top management is crucial for the use of feedback in Health Service organisations, there has been no published empirical research into how boards of directors of NHS trusts – the most senior level of managers in NHS organisations – themselves actually use patient feedback. This is a further substantial gap in the patient feedback research literature, leading to my third subsidiary research question: 'How do the Boards of Directors of NHS Trusts themselves use patient feedback in the management of hospital services?'

To summarise, the primary research question I address in this thesis is 'How is feedback from patients used, or not used, in the management of hospitals in the NHS in England?'. My subsidiary research questions are:

1. In what ways are different kinds of patient feedback used to improve hospital services?
2. How do managers in hospitals use patient feedback to influence and manage the staff who provide services for patients?

3. How do the Boards of Directors of NHS Trusts themselves use patient feedback in the management of hospital services?

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Chapter 3 Methods

3.1 Introduction

In Chapters 1 and 2 of this thesis I have argued that policy, practice and empirical research about feedback from patients in the NHS in England and in health care in other countries have focused more on the collection than on the use of feedback. There is a substantial gap in the research literature relating to the use of patient feedback. The primary question being addressed in this research is therefore: 'How is feedback from patients used, or not used, in the management of hospitals in the NHS in England?'. In this chapter I identify and justify the methodological strategy adopted in the research to address this question. I then describe the methods of data collection and analysis used to translate the strategy into the empirical study and the findings presented in this thesis.

3.2 Methodological Approach and Research Strategy

The study of social processes and social structures depends heavily on the definitions and conceptualisations that are adopted at the start of the research and hence on the ontological assumptions and theoretical approach to the subject matter (Giddens 1979). Although some authors (e.g. Fulop et al. 2001b) outline two main methodological approaches (positivist, and interactionist or interpretive) in the social sciences, others (e.g. Blaikie 2007) identify a wider range including realist, critical and other approaches. In this section I argue that, although interpretive, realist and critical approaches have much to offer the study of the use of patient feedback, the most important first step in filling the gaps in the research literature is to provide a detailed empirical account, drawing on a broadly positivist methodology, of the actual uses of patient feedback in everyday organisational practice. I argue first for a positivist methodology and second for a qualitative research strategy.

Much of the research literature that I have reviewed in Chapter 2, on patient feedback and health service management, has not made explicit its own methodological assumptions or theoretical underpinnings (as noted by Ferlie et al. 2005a in the context of the public management literature more generally). The research, in common with much health services research, has often adopted a broadly empirical approach, observing and describing what exists (or what is assumed to exist) in the world and is directly available for observation by the observer (Bowling 2009). The extent to which this approach can itself be called positivist is open to question; there are many different definitions of positivism itself in the social sciences

as in the natural sciences (Blaikie 2007). If, following Blaikie's summary of positivism, we take the view that reality consists of distinct events that can be experienced and then described by people, that the language used to describe this knowledge consists of concepts that correspond to real objects, and that the truth of statements in this language can be determined by further empirical observations, then we have a potential starting point for empirical research. The research starts with observation; it develops and uses concepts to make statements about the world; these statements can be tested by further observation. My argument here is that this positivist approach, which is implicit but not explicit in nearly all of the research literature I reviewed in Chapter 2, forms a suitable starting point for my study of the use of patient feedback in the management of hospitals; suitable because the use of patient feedback is a topic about which there has been little previous systematic investigation and because it is organisational practice – what actually happens on specific occasions in specific contexts in specific hospitals – that should form the starting point for investigation and analysis. The task of positivist research is to identify and describe the events that are being studied, in this case the different ways in which patient feedback is used in the management of hospitals.

In arguing that a positivist, empirical research paradigm is an appropriate starting point for this research, I am not claiming that it does not have limitations or that other research paradigms would not bring other insights. Interpretive, social realist and critical realist perspectives would all have much to offer. Consideration of their strengths highlights some of the limitations of positivism and the findings that may be based on it and hence point the way towards further research in the future.

Major alternatives to positivist approaches in sociology are based on interactionist or interpretive methodologies. 'According to Interpretivism, the study of social phenomena requires an understanding of the social world people have constructed and which they reproduce through their continuing activities.' (Blaikie 2007 page 124). Action and interaction theories are based on the proposition that social organisations and society more generally are built from the intentions, goals and actions of individuals (Weber 1964). In the action frame of reference, interpretive theories focus on the meanings that individuals attribute to perceptions and actions in the world, and the ways in which these meanings (which are the primary focus of study) then contribute to social action and social relationships more generally (Silverman 1970). Because the 'facts' of social life are dependent on different actors' viewpoints, these viewpoints and the meanings derived from them must be studied to explain social action (Fulop et al. 2001b). The focus of interpretivism on the meanings that people use to construct and reproduce their social worlds provides a basis for

understanding why the social world is as it is. The strength of these approaches is that they can, while remaining grounded in empirical reality, address a broader range of subject matter than more narrowly positivist studies. They focus our attention on the different interpretations that people have of specific events and on the need for careful – or critical – analysis of these differences in examining empirical data.

Despite these strengths, there are significant limitations to an interpretive or hermeneutical approach that mean that they are not the right starting point for the present research. The limitation is that, by focusing so closely on individuals' meanings and actions, researchers may tend to assume that these are the only components of social life, denying the validity and causal powers of social processes in themselves (Sayer 2000). Because part of the focus of the present research is on the ways in which management processes in Trusts and the assumptions about patients and 'improvement' that are embedded in them – social processes and assumptions that may not be consciously articulated by people working in those organisations (Bourdieu 1977) – I argue here that an exclusively interpretive methodology would not prove a satisfactory base for this study. While interpretive approaches have attractions they do not for my purpose replace a basic positivist research paradigm. I focus on the actual use that managers make of patient feedback.

Social realism offers ways of examining and understanding social practices and structures that are not readily identifiable by use of the positivist methodology which underpins much epidemiological and related research in health services or by use of hermeneutical analyses that focus primarily on the interpretations and discourses of actors in the field (Sayer 1992). The defining feature of realism is (in many ways like positivism) the belief that there is a world existing independently of our knowledge of it (Sayer 2000). Social realism also lays emphasis on the nature of social processes and relationships that, although they may be derived in one sense from individuals' actions, have emergent properties that themselves influence individuals and other social processes (Sayer 1992). The strength of social realism from the perspective of the present research is that it provides a more comprehensive ontology and view of what is important in the social world than do positivist, interactionist or interpretive approaches. The challenge would lie in translating the philosophical principles about institutional practice and 'emergent properties' with causal attributes into a specification for empirical observation and research design.

Despite the inherent appeal of a social realist approach, focusing attention on underlying social structures and assumptions that are not readily apparent through everyday observation, the challenges call into question its appropriateness and value

in the present research. As I have argued already the first requirement of the research is to begin to fill a substantial but simple gap in the published research literature, to describe how patient feedback is used in the management of hospitals. When this gap has been filled, when we have the basic descriptive and analytical account of how patient feedback is used, then we will be in a better position to examine the underlying social structures and assumptions that explain why it is used in particular ways. Until that time the realist focus on emergent properties with causal attributes is a distraction from the more basic, but essential, initial research task of describing how feedback is used, of providing detailed and convincing examples grounded on empirical observation that serve as the basis for 'positivist' findings and conclusions. This is my task in this research.

In adopting a positivist methodology, I am focusing on how feedback from patients is actually used in the management of hospitals. I am interested in the decisions that are made and the actions that are taken using patient feedback, and in the ways in which feedback interacts with other organisational processes to influence these decisions and actions. With this as my aim, I will draw on and make use of what people say in interviews and documents. I will necessarily have to interpret and make sense of what they say; but I am not primarily interested in the meaning of what people say for its own sake. Nor am I primarily interested in how actors' own meanings and definitions influence their actions, which I take to be the core focus of interpretivism. Instead I am interested in using the information that interviewees and documents provide to find out about how feedback from patients is actually used; my research examines the uses of feedback, as a set of observable events in the organisational world of the National Health Service.

The focus in this research on the use of patient feedback – examining how feedback is used in specific organisational settings and contexts – suggests that a qualitative research strategy would form the most appropriate basis for the research design and methods and lead to the most worthwhile findings and conclusions. A major focus in qualitative research is not so much the clear definition of specific variables as the description and analysis of the context and processes that influence particular sets of events (Bryman 2008, Maxwell 2012). In qualitative research generally, and especially in the initial stages of that research, the complexity of the phenomena being studied and the uncertainty at the start of the research about what may be found mean that many qualitative researchers have adopted a flexible approach to data collection (Bryman 2008). The gaps in the literature, about the use of patient feedback generally and about the use of feedback by Boards of Directors and in the motivation and management of staff in particular, and the potential richness

of data on these subjects, all suggest that a flexible approach to data collection, with the opportunity to analyse data and develop the investigation as it progresses, will result in a wider range of worthwhile findings than data collection that is rigidly defined at the start of fieldwork.

Qualitative methods will facilitate the uncovering and exploration of material that is not immediately apparent (and therefore is not readily quantifiable) in data derived from interviews, documents and observation. Some authors (e.g. Pope and Mays 2006b, Bryman 2008) explicitly equate interpretative and qualitative research. Bryman (2008 page 366) for example argues that, in addition to the distinction between words and numbers, three features of qualitative research are particularly noteworthy: an inductive view of the relationship between theory and research – theory is generated from observation; an interpretive epistemology – understanding the world through an examination of the interpretations of that world by its participants; and a constructionist ontology – a social phenomenon is the outcome of interactions between individuals ‘rather than being ‘out there’ and separate from those involved in its construction.’ Although these authors argue, from the subjectivity and uniqueness of individuals’ perceptions and the actions that are built on them, that qualitative methods are appropriate for research into organisational processes and assumptions, it does not follow that interpretive research is the only method of studying organisations or that qualitative methods can only be used in interpretive research. Other authors (e.g. Murphy 2001) argue that qualitative research is not inextricably bound up with idealist or relativist assumptions. Qualitative research in this view is concerned with the study and analysis of individual phenomena and the relationships between them (Sayer 1992). It is based on careful observation and analysis but does not involve counting or measuring the phenomena of interest. I follow this latter line of reasoning. Despite the views of Bryman and others that I have outlined above I consider that qualitative research methods can be used to support a positivist research methodology.

By adopting a positivist methodology and a qualitative strategy I will focus as directly as possible on my subject of interest: the ways in which patient feedback is used in the management of services. I am concerned to identify and describe the different uses that are made of patient feedback in the management of hospitals. I am also interested in questions of whether different kinds of feedback, about different domains of patient experience, are used in different ways in the management of services. This does not mean that I should focus primarily on the meanings that managers and others attach to the use of feedback; nor does it mean that I have to adopt quantitative research methods. It does require clear observation and analysis

of the individual examples of the use of feedback that I can identify on the basis of data collection in the field.

3.3 Research Design, Access and Approvals

In the last section I have argued that qualitative research methods to support a positivist research methodology form an appropriate research strategy for my study. In this section I look more closely at the design of the research, the framework through which I will seek answers to the research questions I have posed.

Textbooks on research methods (e.g. Alasuutari et al. 2008, Bowling 2009) identify and discuss a considerable variety of research designs – case studies, organisational ethnography, narrative histories, action research – that support qualitative research strategies. My aim in designing this study was to keep a clear focus on the descriptive and analytic purpose of the research – to identify and describe the different ways in which feedback from patients is used in the management of hospitals. In pursuing this aim I wanted to achieve a combination of breadth of coverage and depth of analysis that would complement the existing research literature and help fill the gaps in it. Breadth of coverage was important because most of the published research studies had focused on a single kind of feedback such as surveys, complaints or patient involvement forums. I wanted to understand how different kinds of patient feedback were used. At the same time I did not want simply to produce a catalogue of different kinds and different uses of patient feedback. I wanted to understand in depth how feedback was used in all the complexity of real-life management processes in hospitals. This combination of breadth of description and depth of analysis suggested to me that I should adopt a research design, drawing on multiple sources of data in multiple settings.

In designing the study in this way I drew on the case study research literature but did not define my own research as a case study. Case studies are specifically suited to the deep understanding and explanation of complex social phenomena, especially where phenomena and the relationships between them are not well defined (Bowling 2009), where there is no clear, simple set of outcomes (Locock et al. 2005), and where the relationships between human motivation and action are not readily revealed (Mabry 2008). Yin (2009) argues that case studies are the preferred method of social research when the investigator is addressing ‘how’ or ‘why’ questions, when s/he has little control over the events being studied, and when the focus is on a contemporary phenomenon in a real-life setting. Case studies may be exploratory, descriptive or explanatory. These ideas were important to me because, quite clearly in my area of interest, there was no clear, simple set of outcomes and as an

investigator I would have no control over what actually happened in the hospitals where feedback was being used. This literature reinforced my sense of the importance of asking simple 'how' and 'why' research questions and the value of collecting and using multiple sources of evidence in multiple settings to answer these questions. My focus has been not on 'cases' but on the collection and analysis of data about the use of patient feedback in different settings.

My aim in designing the present research has been to identify and select two hospitals with different approaches to the collection and use of patient feedback, in order to broaden my analysis of the ways in which feedback is used. In discussing the definition and selection of study settings, Mabry (2008 page 217) suggests that 'Where a case is thought to be representative of a larger population, a *typical* case study may be useful for identifying and documenting patterns of ordinary events, the social and political structures that sustain them, and the underlying values and perceptions of participants'. Atypical examples may be particularly enlightening because they defy expectations, leading the investigator to revised or new theorising about the nature of and reasons for the events being studied. 'Polar types' help make processes of interest transparently observable (Eisenhardt 1989). Where more than one instance is to be studied the selection of contrasting examples may provide a fuller picture of the events being studied. I selected Hillside and Northbank Hospitals as the settings for this study (as discussed below) largely because of the contrasting emphases in the hospitals on the collection and use of feedback.

Ferlie and Mark (2002) argue that research based on single settings and examples has often been non-cumulative and non-generalisable. The limitations of single setting studies can be overcome by selection and analysis of multiple settings. The purpose of studying multiple settings is not so much the simple addition of facts or the production of immediate statistical generalisations as the comparison and synthesis of different analyses to produce new concepts and interpretations that encompass divergent material. The combination of data from different settings may result in the development of concepts and explanations that are not inherent in the data from any one of the settings individually (Locock et al. 2005). In this study I decided to select two contrasting settings within similar external environments in order to focus the analysis more clearly on the relationships between different organisational processes and the uses of patient feedback. The study of the use of feedback in two hospitals, which differed in the collection and use of different kinds of patient feedback but were similar in their organisational and external environments, would facilitate in depth analysis of the relationships between organisational

processes and priorities and the actual collection and use of the different kinds of feedback.

The focus of this research is the use of patient feedback in two hospital trusts in the NHS in England. I confined the study to England because of the practical constraints on in-depth cross-national research and because the research literature (e.g. Crawford et al. 2002, Davies and Cleary 2005, Reeves and Seccombe 2008, Hsieh 2009) suggests many similarities between England and other 'developed' countries. The focus is on the National Health Service because the NHS provides the large majority of health services in England and because government policies about the collection and use of patient feedback apply most directly to the NHS. The study therefore provides an opportunity to examine the interactions between government policy about a public service and the actual practice to which that policy relates. The focus is on acute hospitals (rather than on other NHS organisations) partly because the use of patient feedback appears to be most developed in hospitals (Brown et al. 2009) and partly because hospitals are subject to greater pressures from central government and regulators than other NHS organisations, providing the best opportunity for studying in depth the context in which patient feedback is used in the management of services.

I undertook the study in two acute general hospital trusts selected purposively to maximise insights into the organisational processes that influence the use of patient feedback. One trust (pseudonymised here as Hillside Hospital NHS Foundation Trust) was selected because of its well-established practice and reputation in using feedback to improve services. It introduced an in-patient survey (referred to throughout this thesis by its name 'How Are We Doing?' abbreviated in the Trust to HRWD) in 2004, well before local surveys became part of the mainstream in the NHS. The Hospital in 2011 received more than 1,200 completed in-patient HRWD questionnaires a month, and collected real-time feedback in outpatient clinics and the emergency department and in 'quality ward rounds'. It was able to demonstrate a wide range of uses of surveys, complaints and other kinds of feedback in improving 'patient experience', in improving services and developing new services, in training staff, and in developing policies. The emphasis in the Trust's Annual Report for 2009/10 was on practical improvements in services resulting from patient feedback. These features suggested that Hillside Hospital was an atypical or polar example (Eisenhardt 1989, Mabry 2008) of the use of feedback, meaning that its inclusion in the study should provide particular insights into the organisational processes associated with the use of feedback.

I selected Northbank Hospitals NHS Foundation Trust (also a pseudonym) for inclusion in the study because as a large, inner-city, NHS foundation trust it was in many ways similar to Hillside; but Northbank differed in its approach to the collection and use of feedback from patients. Northbank was a similar acute university hospital NHS foundation trust, based in broadly the same geographical area and external organisational environment as Hillside (although with two main hospitals pseudonymised here as St. Dunstan's and Wastell Hospitals), but appeared to have a different emphasis in the collection and use of feedback from patients, focusing more on patient involvement in service development than on patient surveys. The Trust had commissioned since 2006 a quarterly telephone survey of patients, with interviews of 1,000 in-patients or day case patients each quarter; but this was discontinued in March 2011 as plans for new real-time electronic feedback were being implemented. The Trust did have a substantial history of involving patients in service planning and development (using patient focus groups and experience-based design methodologies) since the early 2000s as part of the NHS Modernisation Initiative supported by the NHS Modernisation Agency and by substantial funding from the Trust's local charitable sources. The emphasis in the Trust was on patient involvement rather than patient feedback.

The two Trusts in 2011 together provided the local hospital services for the people of three inner city local authority areas with an ethnically and culturally diverse population of about 850,000 people. Both Trusts also provided a wide range of more specialised services for people living outside the local area. Clinical services at Hillside Hospital were managed in nine divisions (Cardiovascular; Child Health; Haematology; Liver; Neurosciences; Renal; Surgery; Trauma, Emergency and Acute Medicine; and Women's Health) each managed by a general manager. The Hospital claimed a particular recognition for its work in liver disease and transplantation, neurosciences, haemato-oncology, major trauma and stroke. Clinical services at Northbank were managed in 14 directorates (Acute Medicine and Gastrointestinal Surgery; Cardiovascular Services; Children's Services; Clinical Imaging and Medical Physics; Genetics, Rheumatology, Infection, Dermatology and Allergy; Medical Specialties; Oncology and Haematology and Cellular Pathology; Perioperative, Critical Care and Pain; Pharmacy; Renal, Transplant and Urology; Surgery; Therapies; Women's Services) each managed by a clinical director. The Trust claimed particular recognition for its work in cardiothoracic, cancer, and renal services for adults, as well as for a wide range of specialist children's hospital services. Hillside Hospital, with about 7,000 members of staff and income in 2010/11 of about £600 million, treated about 140,000 people as in-patients or day cases in one year;

Northbank Hospitals, with about 12,000 staff and an income of about £1,000 million, treated about 150,000 in-patients and day cases. Both Trusts worked closely with the major local university and were directly involved in the education and training of doctors, nurses, dentists and other health professions, and participated in a wide range of biomedical, clinical and service-related research. Both Trusts also worked together, along with the local specialist mental health trust and with the local university in an academic health partnership intended to promote collaboration and the translation of academic research into clinical practice and service improvement.

The similarity of geographical and organisational contexts of the two Trusts means that the analysis of data can focus more clearly on the actual use of patient feedback inside the inside the two organisations. The research is defined in terms of the use of patient feedback, rather than the focus being on the collection of feedback or on the management of each hospital as a whole. But, as a result of discussion with key contacts and the information gained in the first group of interviews, I realised that it would be impossible to obtain a comprehensive picture of the use of feedback throughout the two very large hospital Trusts. I needed therefore to identify and select specific areas or issues as the focus for more detailed data collection and analysis, areas that themselves in accordance with the purposive selection of the two Trusts as the study settings would help identify and illustrate specific uses of patient feedback.

In making these selections I decided to focus on one service improvement initiative and one clinical service in each Trust. I selected an out-patient improvement initiative at Northbank Hospitals because complaints by patients and problems with the service were the subject of vigorous discussion at the very first Board of Directors meeting I observed in January 2011; this led me to focus not only on the improvement initiative but also in due course on the role of Boards of Directors in using feedback. I selected a food and feeding initiative at Hillside Hospital partly because early interviewees talked about it as a substantial example of the use of feedback from surveys and partly because my observation of the Board of Directors meeting in March raised interesting questions about how the Board used feedback to monitor service changes and improvements. Because both of these examples focused on specific improvement initiatives concerned primarily with non-clinical support services, I decided also to focus on one clinical service in each Trust. I decided, on the basis of interview data and informal discussions with interviewees, to focus interviews at Hillside Hospital on neurosciences, where patients' complaints and surveys were said to have led to substantial initiatives directly overseen by the Trust's executive directors to improve the quality of care; and at Northbank Hospitals on

cancer services, where there was a substantial tradition of patient involvement in the development of services including the development of a new chemotherapy day unit. The selection of these four examples thus provided me with detailed data about the use of different kinds of feedback (complaints and surveys), different domains of feedback (administrative and 'hotel' services, clinical care, and the environment of care), and different uses of feedback (service improvement initiatives, the design and delivery of care). The examples provided me with detailed data about the use of feedback in a variety of different organisational contexts.

Requests for access to the two Trusts for the research study were planned following the outline suggested by Bowling (2009, page 388). The practicalities of obtaining these approvals for access appear not be discussed in detail in the major textbooks on social research, but turned out in this instance to be complex and time-consuming. I held initial discussions about the study, based on a short paper outlining the research prepared in March 2010, with senior managers in the two Trusts in the spring and summer of that year. A research protocol for the study was first drafted in April 2010 and was discussed as a draft with potential participants in the Trusts. The protocol was also discussed in detail with the research and development office of Hillside Hospital Trust, who decided that the study did not need formal NHS R&D approval. The protocol was revised and then served as the basis for the identification of directors in the two Trusts to be 'local collaborators' for the study, whose role would be to help secure access and ensure that fieldwork was carried out consistently with the protocol and acceptably from the Trust's point of view. Information and consent sheets for potential participants in the research were prepared and used with interviewees and other participants during fieldwork; copies are shown in Appendix 1 to this thesis. After protracted discussions, approval for access to the Trusts on the basis of the research protocol was obtained (in the form of e-mails sent by or on behalf of the director-level local collaborators) in February 2011. After further discussions in Northbank Trust, this access was confirmed there in the same way by the same director in May. The process of discussing and agreeing research access to the Trusts took just over one year.

Ethical aspects of the study were planned in accordance with the six principles of the ESRC's research ethics framework (Bryman 2008, page 127). An application for ethical approval was initially drafted through the NHS Integrated Research Application System (IRAS). The draft research protocol was discussed in early summer 2010 with the relevant local NHS Research Ethics Committee which formally stated in June that, because the study did not involve contact with or data about individual patients, it would not require NHS ethical approval. Following significant

redrafting of the research questions and strategy in the autumn of 2010, ethical approval for the study was sought and obtained through the King's College, London internal system in February 2011, leading to the finalisation of the protocol also in February.

Access to the Trusts was granted on the basis that all information provided through interviews and observation to which formal consent of relevant staff had been obtained could be used without further comment or approval from the Trusts in anonymised form in any publications or reports arising from the study. Subsequently, in the summer of 2011, a request to the Director of Operations at Hillside Hospital to observe the performance review meetings that he chaired raised his concern that this might result in the disclosure of sensitive or confidential information that might damage the services or reputation of the Trust. After substantial discussions it was agreed in the autumn that these meetings could be observed as part of the research on condition that any material arising from them was submitted to the director-level 'local collaborator' for her approval before it was used and that she would respond to the request within four weeks. This gave the Trust the right of veto over the use in the research findings of a limited part of the data. Without this provision access to these meetings would not have been granted. The draft findings from these observations were sent to the local collaborator in September 2012. She was reminded about the request subsequently four times but failed to respond; and was therefore informed in November that the material she had been sent would now be used in the research.

3.4 Data Collection

In Sections 3.2 and 3.3 I argued that a qualitative research strategy and the collection of data from two NHS Trusts would provide the focus and flexibility needed to begin to fill the gaps in the published research literature about the use of patient feedback. In this section I describe the methods of data collection used to achieve this aim. In Section 3.4.1 I describe and comment on the development of my data collection strategy; in the following sub-sections I describe in detail my data collection through interviews, the observation of meetings, and the collation and analysis of documents.

3.4.1 Overview

The qualitative research strategy I described in Sections 3.2 and 3.3 leads to a variety of options for data collection. It was from the start of the project my intention to interview managers to obtain data about the collection and use of patient feedback;

interviewees would, I thought, tell me how patient feedback was used in their Trust. A major focus in qualitative research is not so much the clear definition of specific variables as the description and analysis of the context and processes that influence particular sets of events (Bryman 2008, Maxwell 2012). In qualitative research the complexity of the phenomena being studied and the uncertainty at the start of the research about what may be found mean that many qualitative researchers have adopted a flexible approach to data collection (Bryman 2008). Data are not constrained to a single source that is defined before the beginning of data collection. But this flexibility does not mean that the researcher is at liberty to adopt a scatter-gun or serendipitous approach to data collection in the hope that something interesting will emerge. It means rather that, as the investigation proceeds, the researcher can decide to sharpen the focus of the investigation and adopt new methods of data collection that are appropriate to the new topics and themes of analytical interest.

My collection of data developed in stages that reflected both the development of analytical interests and the strengths and limitations of the individual sources of data. Before the start of fieldwork at Hillside and Northbank Hospitals I read and annotated Department of Health policy documents and guidance since 1997 about the collection and use of patient feedback and about the NHS and health care more generally. This provided contextual and background information, but also led to the specific observation that policy said far more about the collection than the use of feedback. I also at this stage read the Annual Reports, Quality Accounts and public web pages of the Hillside and Northbank Hospitals to get a breadth of background information about the Trusts that might have been obtainable through interview but that would not have been a good use of scarce interviewee time. At the start of fieldwork, before final agreement to interviews had been given, I also obtained the public papers for and observed the first meetings in public of the Boards of Directors of Hillside and Northbank Hospitals. Although I had intended this simply as a way of obtaining more background information before the start of data collection proper, observation of the meetings at both Trusts led immediately though in different ways to empirical and analytical interests that were developed through further data collection: the use of local survey results in decision making by the Board at Hillside; and the out-patient improvement initiative at Northbank. In these ways the very early stages of data collection showed me the potential advantages of a flexible approach to using multiple sources of data.

The value of documents as a major source of evidence became increasingly apparent to me during the main stage of data collection in 2011 and afterwards as I

was analysing data and writing up the findings. During the main data collection in 2011 I continued to collect publicly available documents including the Annual Plans, Annual Reports and Quality Accounts and all the public Board papers from the Trusts, but did not make substantial use of them at the time to develop my thinking in the way that I had done with interviews and observation of meetings. After the end of formal data collection, as I was seeking specific pieces of evidence on particular issues raised in interviews I came increasingly to draw on documentary evidence. This on occasion led me to identify and study documents that I had not previously accessed. Some of these documents, from 2009, 2010 or earlier years, were accessed through the Trusts' public archives. Some (including for example quantitative performance reports to Trust Boards) were documents from 2011 that I had previously obtained but had not begun to analyse in depth. Others were from 2012 and 2013, allowing me to track follow-up actions and to begin to test the impact of the use of feedback in the Trusts. I present the results of some of this analysis in Chapter 4. The point here is that the continuing availability and stability of documents as a source of evidence meant that government and Trust documents were not as I had originally intended simply a source of data to supplement interviews but became an essential and equal source in their own right. The documents were available not only as repositories and hence sources of information about the use of patient feedback in the Trusts but also as evidence in themselves of the organisational functioning in the use of feedback (Prior 2008), an issue which I examine in Chapter 6.5 about out-patient improvement initiative at Northbank Hospitals.

I began preliminary data collection, in the form of collation and reading of government policy and Department of Health guidance early in 2010 and of public documents from the two Trusts in the autumn of 2010. I began fieldwork in the form of observation of public meetings and collection of associated papers in January 2011. The first interviews with managers were held in March 2011. The final interviews were held in November 2011 and the final meeting observed in January 2012. I continued to access current documents from the Trusts' websites and other websites during 2012 (and to a limited extent subsequently). So, although the main period of interviews and observation in the two Trusts took just over one year, the broader process of accessing and collating documents lasted considerably longer.

I undertook the fieldwork observing and collecting data and, as appropriate, discussing emerging findings with the staff of each Trust, in order to develop the analysis and guide further data collection (Bryman 2008). These discussions took place both before and after formally recorded interviews, through deliberately arranged meetings or telephone conversations with key collaborators, and during

encounters in the hospitals at other times. These discussions did not on the whole make substantial contributions to the development of theoretical analysis or understanding, but did add useful information about developments taking place in the Trust and did help clarify unclear matters of fact in existing data. They were essential in guiding me towards data collection and analysis about the neuroscience services at Hillside and the cancer services at Northbank Hospitals.

Following a simplified version of Silverman's (2005) procedure for qualitative fieldwork, I made and maintained two sets of field notes for each Trust: data recording sheets that contain notes of the direct observations I made at the time or shortly after a fieldwork session; and a fieldwork journal that contained a log of research activity and my notes of ideas, problems and issues and a provisional running record of analysis and interpretation. I used a summary sheet to keep a working record of the actions taken and next steps needed in arranging interviews and observation of meetings. This detailed log contained individual records of 49 of the interviews and 17 of the meetings I observed, and notes about other discussions held and documents obtained during fieldwork but on condition that they were not to be used as data. The records of individual interviews and meetings commented on the adequacy of the method or particular episode of data collection and highlighted particular empirical or theoretical issues to be investigated further for subsequent investigation or analysis. The value of the log lay both in helping to plan the next stages of data collection (e.g. in identifying when coverage of a particular part of the organisation was felt not to be generating substantial new data) and in providing a source for a retrospective overview of substantive and methodological issues (e.g. the interactions between patient feedback and other sources of action in developing service improvement initiatives; the variation between interviewees in the ways in which they answered questions in the interviews) that might not otherwise have been so readily apparent after the end of fieldwork.

3.4.2 Interviews

I identified potential interviewees for inclusion in the study on the basis of purposive sampling (Bowling 2009, Bryman 2008), with the aim of maximising the amount of data I could collect from people with actual knowledge and experience of the use of patient feedback in each Trust. My initial aim was to identify interviewees with experience of using patient feedback in management roles in different parts of the Trusts (executive directors, corporate managers, directorate managers, and clinical and non-clinical service managers). I aimed to identify how feedback was seen and used in a wide range of organisational settings in each Trust. At the same

time I wanted to take account of the occupational or professional nature of interviewees' primary roles (general managers, doctors, nurses, other health professionals) in order to ensure that findings about the use of patient feedback did not depend simply on data gathered from general managers or any other single occupational group. My second and increasingly important aim as fieldwork developed was to interview managers with experience of the use of patient feedback in the context of one or other of the emerging empirical foci of the study, neurosciences or the food and feeding initiative at Hillside Hospital, cancer services or the out-patient improvement initiative at Northbank. This reflected my aim of collecting detailed, in depth data about specific examples of actual use of patient feedback.

With these aims in mind I asked my initial contacts and early interviewees to suggest the names of other managers and clinical staff with managerial responsibilities whom I could approach to interview. My initial interviews were with patient experience, complaints, and PALS managers in each Trust because they had been identified in preliminary discussions as the staff most directly involved in the collection, dissemination and use of patient feedback, and thus best able to provide descriptions of the collection and use of feedback. At the end of each interview each of these interviewees was asked about the names of corporate directors and their deputies with overall responsibility for the collection and use of patient feedback. The corporate directors and managers in turn were asked for suggestions for clinical or service directors who would be suitable, on the grounds that they or their service had experience of and interest in the use of patient feedback to be interviewed. The clinical and service directors were similarly asked for suggestions about service managers and senior clinical staff with management responsibilities to be interviewed. Two of the governors were selected because I had observed at Board meetings that they had particular interest in one of the examples I was studying; the other two themselves asked to be interviewed for the study. The resulting sample of interviewees was therefore not in any sense a random or representative sample of managers in each Trust as a whole but was intended to generate a range of organisational perspectives on a focused set of issues associated with the use of patient feedback.

A total of 58 people were approached initially by e-mail or in person for interview. One (a clinical director) refused and two (an executive director and a nurse practitioner), despite follow-up requests by email and telephone messages, did not reply. Two interviewees were accompanied at the interview by colleagues, meaning that 57 people participated in the 55 interviews that were held between March and

November 2011. Table 3.1 on the next page shows the broad organisational and managerial roles of the 57 interviewees. In order to demonstrate the range of roles and responsibilities of the interviewees, the table also identifies the more detailed job titles of a selection of these interviewees.

Table 3.1 Completed Interviews: Role of Interviewees

Role of Interviewee	Hillside	Northbank	Total
<u>Executive Directors and Corporate Managers</u>			
Executive and Other Directors (e.g. Chief Executive, Director of Nursing, Director of Operations, Director of Human Resources, Director of Corporate Affairs)	4	3	7
Corporate Managers (e.g. Deputy Director of Strategy, Assistant Director of Performance and Contracts, Deputy Chief Nurse, Patient and Public Involvement Manager, PALS Manager, Complaints Manager, General Manager for Patient Support Services)	9	8	17
<u>Divisional and Directorate Managers</u>	6	9	15
(e.g. Clinical Director, Divisional General Manager, Programme Manager, Head of Nursing)			
<u>Service and Clinical Managers</u>			
Service and Ward Managers (e.g. Ward Manager, Service Manager, Service Improvement Lead, Clinical Governance Facilitator, Change Leader)	3	3	6
Clinical Practitioners with Management Responsibilities (e.g. Consultant Surgeon (Head of Service), Consultant Physician (Lead Consultant), Consultant Nurse, Practice Development Nurse, Clinical Lead Speech and Language Therapy)	4	4	8
<u>Governors</u>	3	1	4
Total	29	28	57

Table 3.1 reflects the range of organisational roles and responsibilities of the people I interviewed. As fieldwork developed I also identified and selected interviewees who would be able to provide me with detailed information about one or more of the four examples of the use of feedback that I was beginning to study in closer detail. As a result at Hillside Hospital I interviewed seven people who had a particular involvement in neuroscience services and four in the food and feeding initiative. At Northbank I interviewed 10 who were involved in cancer services and five in the out-patient improvement initiative. These 26 individuals are included in the numbers in Table 3.1. In the interviews with these people I focused primarily on their experience of patient feedback in the specific example I was studying, but also asked the same set of more general questions about the different kinds and uses of feedback that I asked all interviewees. This approach meant that I was able to collect not only detailed information about specific topics but also to increase the total amount of data I collected on the broader issues of feedback.

I held five main groups of interviews in each Trust: patient experience, complaints and PALS managers (interviewed in March); executive and corporate directors (May to July); clinical and service directors and other heads of service (June to September); front line service managers and clinical managers (August to October); and Trust governors (November). Interviews lasted between about 25 and 80 minutes, with the majority lasting between 30 and 45 minutes. I undertook and electronically audio recorded all the interviews myself.

My interview strategy was based on the aim of collecting data that would not only describe actual practice in the collection and use of patient feedback but would also help uncover the organisational processes and assumptions underpinning its use. The aim in Bowling's (2009 page 411) words was '... to encourage respondents to talk freely and spontaneously about their feelings, experiences, attitudes and behaviour.' Interviews were 'tools' designed to elicit interviewees' authentic accounts of practical and subjective experience, rather than intended themselves to be an interactionist or constructivist topic for investigation in their own right (Alveson 2003, Silverman 2005).

I developed draft interview topic guides focusing on the research questions and tested them in three pilot interviews with health service managers from NHS Trusts not involved in the main study. The piloting showed that the interviewees were able to respond clearly and fully to most of the questions but that they were not always able to provide information about the background to and history of the collection and use of patient feedback, issues in which they had not been personally involved in their

jobs. The piloting resulted in changes to the topic guide by the inclusion of an introductory question asking interviewees to describe their job and main responsibilities, by excluding questions (for most interviewees) about the history of the collection use of feedback in the Trust (so that the interviews focused in more depth and detail on the actual experience of interviewees in the collection and use of feedback), and by the alteration of wording of some questions to reduce ambiguity and risk of misinterpretation (e.g. in distinguishing between the aims of using feedback and the priority given to the use of feedback). These changes led, later in data collection, to an increased focus on Trust documents to provide factual information about recent practice and past events in the use of feedback.

The interview topic guide was designed following the process outlined by Bryman (2008 page 446) linking the main research question underlying the study with specific interview questions.

- Kinds of patient feedback: questions asking interviewees to identify and describe the different kinds of patient feedback they were involved with in their jobs – the sources and different methods of collecting feedback, and the contents or issues raised in feedback.
- Uses of patient feedback: questions asking interviewees to identify and describe the different uses of patient feedback they were involved with in their jobs – what feedback was used for.
- Organisational processes: questions asking interviewees to describe and talk through the decisions, meetings and organisational processes through which feedback was (or was not) used; questions about the aims and priority of collecting and using patient feedback; plus comments at other points in the interviews about the contents of feedback and relationships between service users and providers.

At each stage of the interviews the topic guide said interviewees should be asked to give practical examples in which they had been involved of feedback and its use in the Trust, focusing on how things had happened in order to help build the picture of why they had happened (Yin 2009 pages 106 ff.). The interview guide I used for directorate and divisional managers is included as Appendix 2.

I changed the interview topic guide, sometimes quite significantly, for different interviewees, to reflect the particular purpose of an interview with a particular individual, getting close to their experience of using patient feedback and hence

uncovering the perceptions and assumptions on which organisational processes were based (Silverman 1970). Interviews with middle level corporate and directorate managers directly responsible for patient feedback focused mainly on identifying the different kinds of feedback in the Trust, the ways in which they were collected, and the routine organisational processes involved in their use. Trust directors were asked more about the overall strategy and history of patient feedback in the Trusts. They were also asked about their personal involvement in the use of feedback, following up specific things that they had said in Board meetings or that other interviewees had said about them, in attempts to get a fuller understanding of the leadership of the Trust in relation to patient experience and patient feedback. Doctors and other clinical managers were asked about the feedback they received from patients in the course of their clinical work and how they then used that information in the management of the services locally.

My main aim throughout the interviews was to identify sufficient factual material and examples to provide an account of how patient feedback was collected and used in the management of services. The interviews were designed around focused semi-structured interview topic guides, with sufficient flexibility for supplementary questions to explore in depth topics of interest that arose, rather than as guided conversations (Yin 2009 page 107). The ways in which questions were asked, and the amount of detail sought in supplementary questions, varied within and between interviews. I used prompts to ask about matters that I knew from previous interviews to be relevant (e.g. the collection and use of national survey data) but which had not been mentioned by the current interviewee. Follow-up questions asking for more detail about specific issues were used mainly in relation to the main kinds of feedback and its use, or to explore an issue that had not been previously identified in any previous interviews. I tried to ask questions in a low-key, friendly and informal style. In the interviews I tried to accept the interviewee's responses, and to maintain a neutral but positive attitude towards what the interviewee was saying (Bowling 2009 pages 411 – 412). The audio recording of the whole of each interview then formed the initial source of data ready for transcription.

3.4.3 Observation of Meetings

Observation in qualitative research provides direct evidence in natural settings of the issues being studied (Yin 2009). It provides opportunities to gather data about the context of complex social situations that may not easily be uncovered in interviews (Bowling 2009). My main aims of observation of meetings in the present study were

to identify in detail the ways in which patient feedback was used in specific contexts and to describe those contexts themselves as part of the route to understanding why feedback is or is not used in particular ways.

Although I had considered in the early stages of planning fieldwork attempting a wide ranging set of observational activities as part of an ethnographic approach within the Trusts, I made an early decision, given the size and complexity of the organisations and guidance in preliminary discussions in the Trusts about the likelihood of obtaining access to everyday working activities, to adopt an approach using focused observations of specific meetings in each Trust. Observation focused on two main sets of meetings: the meetings in public of the Boards of Directors of the two Trusts; and the regular performance management and scorecard meetings between the executive directors of the Trusts and their directorate or divisional managers.

The Boards of Directors' meetings were selected originally partly because of their convenience (Bryman 2008, page 183) as a meeting open to the public and because of their role in making formal decisions about the development and quality of services, and hence the use of patient feedback, as part of the formal governance of the Trusts. My main aims in observing these meetings were first to understand at the broadest level the context, the strategic direction, and the priorities and pressures in the month-to-month business of managing the Trust – the environment in which feedback from patients is collected and used – and second to examine how patient feedback was used at board level in formal decision-making about the Trust's services and resources. This second aim became increasingly important as fieldwork progressed; it led to specific interview questions to Trust directors and governors and is the major part of the focus in Chapter 6 of this thesis.

The performance and scorecard meetings were selected because of their relevance to questions about how the use of patient feedback within the Trusts relates to the delivery of operational and financial targets: theory-driven questions about the relationship between consumerism and performance management in public services. The main aim of observing these meetings was to see how far the views of interviewees about the importance and organisational priority of patient feedback were reflected in actual practice in formal organisational procedures for management of services and resources.

Observation of the meetings in public of the boards of directors began in January 2011 and continued until December 2011. Although I had originally planned

to observe three or four board meetings in each Trust, I decided during the course of fieldwork to extend this to a whole year's observation. Observation of a smaller number of meetings provided what appeared to be a full understanding of the ways in which each Board worked in general terms and of the ways in which it used (or did not use) patient feedback on a regular basis. But the changing organisational environment through the year, partly in terms of the annual planning cycle but more importantly in terms of the changing priorities and developing strategies at board level within the year (especially the pressure on the quality of out-patient services, the introduction of new methods of collecting patient feedback, and the development of a quality strategy in Northbank Hospitals) meant that continuing observations for a whole year provided greater insight into the factors influencing the use of patient feedback in the Trusts. The decision to continue observation for the whole year also made it easier for me to approach executive directors and governors with requests for interview; they already knew me and what I was doing. It also proved useful in generating sequences of observational and documentary data over the whole year that have then formed the basis of the detailed analyses of neurosciences at Hillside Hospital and the out-patient improvement initiative and the development and monitoring of the quality strategy at Northbank Hospitals that I present in later chapters.

All meetings in public (eight at Northbank and 12 at Hillside) of the Boards of Directors were observed. The fact of the meetings being in public (and hence open to the press or any individuals who wished to attend) had some implications for the research. Although the chairmen and many of the directors were aware (because I had introduced myself to them) of my presence as a researcher (and came to greet me as a regular attender as a member of the public) there were only two occasions in the meetings when my presence or the research was explicitly referred to by a director. More substantially, the fact of the meetings being held in public meant that, although decisions about sensitive or difficult issues were formally made at the meetings, much of the discussion about the issues had been held in private by managers or in committee before the formal board meetings. These private discussions were often referred to in public, and included for example serious incidents and problems with clinical services, financial pressures, and commercial or contractual matters. Data from the meetings in public therefore almost certainly do not form the totality of the context for the ways in which patient feedback is used by the Boards. Meetings held in public discuss only those issues that the people who run the meeting wish to discuss in public.

My observation of performance management and scorecard meetings in the Trusts began in August 2011 and continued until January 2012. A total of 10 meetings (three at Northbank and seven, including four performance review meetings and three nursing and midwifery scorecard meetings, at Hillside) were observed. Fewer were observed at Northbank than Hillside because it appeared at an early stage of preliminary analysis of data from interviews and observation of the Board of Directors that there was a clear relationship at Northbank between the use of feedback and performance management that was reflected in the performance management meetings, and because there was a more complex relationship at Hillside that needed to be assessed through more detailed observation.

Working meetings in the two Trusts were observed between January 2011 and January 2012 as part of the data collection for the study, as shown in Table 3.2.

Table 3.2 Observation of Meetings

Meeting	Hillside	Northbank	Total
Board of Directors (Meetings in Public)	12	8	20
Performance and Other Trust Management Meetings	7	3	10
Total	19	11	30

Appendix 3 contains a detailed list identifying the meetings that I observed as part of data collection and fieldwork for this study.

The development of my observational strategy at these meetings steered a course between structured or systematic observation using detailed recording instruments with pre-defined categories and unstructured observation leading to grounded theory (Bryman 2008, Bowling 2009). I made an initial attempt (as discussed below) to develop and use a simple but systematic pre-coded recording schedule, but the difficulties in using it led me to a focused, semi-structured approach to observation. This approach concentrated on identifying and making a written record in the meetings being observed of everything that was said and done that related directly to the collection and use of patient feedback. I also kept outline records of discussions that did not include patient feedback but which related to contextual issues such as Trust strategy, quality reports, or operational targets and performance. In addition I made notes identifying the agenda heading for other items,

such as finance or estates developments, where feedback was not mentioned and the topic under discussion served only as an indicator of all the other issues being addressed in the management of the hospitals. This strategy was thus intended to provide a focused but open-ended record of what happened and the context in which it happened relating to the collection and use of patient feedback.

My initial approach to recording data in the Board meetings was an attempt to record observations systematically on a simple data collection form that recorded background information about the setting, participants and broad tasks being undertaken and issues being discussed; the form had space for recording 'who does what; who says what?'; and then identified references or links to other documents or data. My attempts to use this form in the first meetings showed that there was too much material of too great a variety in any one discussion or meeting to fit easily into the form, and that concentrating on the form made it more difficult to listen to and make a record of the sometimes very brief or complex comments about patient feedback made in the course of a fast-moving, wider discussion.

I decided therefore simply to listen to the discussion and write down in long hand on paper what was said about patient feedback and closely related matters such as patient experience. I attempted 'to record *descriptions* rather than mere impressions. In practice, this means that we should always try to note concrete instances of what people have said or done, using verbatim quotations and 'flat' (or unadorned) descriptions.' (Silverman 2005 page 93). These hand written notes identified in each meeting the initials of the speaker and summarised as fully as possible the main points about patient feedback made by each speaker. Quotation marks were put round any words or sentences actually used by the speaker. When one speaker made several points very quickly or several speakers spoke quickly one after another it was not possible to make a record of some of the things that were said. My notes of each meeting also contained a record of the agenda items or issues in which patient feedback was not mentioned in discussion. After the end of each meeting I typed the hand written notes, with minimal editing only to correct obvious errors in recording, and stored them electronically to form part of the data set for the study. The data from the observation of meetings is therefore my direct summary of what was said and done in the meetings, as distinct from the Trust's own documentary record of the meeting or my subsequent commentary in the research log on the meetings. These typed observation notes were the data I analysed. Appendix 3 also contains a record (derived directly from my observation notes) of all the agenda items

at the Board meetings in the discussion of which there was some mention of or fuller exchange of views about feedback from patients.

One of the main risks of observation as a method of data collection is bias in the findings because of changes in behaviour resulting from the presence of the researcher (Bowling 2009 page 306). Directors in the board of directors' meetings knew of and acknowledged my presence. At two meetings remarks about patient feedback were made in the course of meetings that appeared to be asides directed at me. But bias in board of directors' meetings held in public is most unlikely to have occurred because of the very nature of the meetings being in public; there were always at least three or four people in addition to myself sitting on chairs reserved for the public away from the meeting table. The question of bias in the performance meetings was more difficult to assess. The meetings were small, with between six and 12 people attending, sometimes in crowded offices. I had previously negotiated access with the chair of the meeting; I introduced myself, outlined the research and obtained consent at each meeting; and then sat to one side making hand-written notes. No obvious signs of bias (in the sense of staff asking for specific material not to be recorded in data collection, or appearing to withhold or change comments while looking at the researcher) were noted. After two of the meetings I spoke informally to the chair and was told that what had happened was fairly typical of the meetings. It can be argued therefore that the data from the observation of these meetings is not likely to have been biased by my presence.

3.4.4 Documents

There are arguably (Bowling 2009, Prior 2008, Silverman 2005) three main approaches to the use of documents in social research. The first is to treat documents as resources, sources of information that can be examined and analysed to get a better understanding of how a social institution operates (exemplifying 'positivist' or 'social science' methodologies). The second is to focus on questions about how the documents are assembled and evaluated, how they come to be what they are (following 'phenomenological' or 'qualitative' methodologies). The third is to examine the ways in which documents are used in practical activities, documents as agents in networks of action. For the reasons I gave in Section 3.2 I am in this research adopting a broadly positivist, rather than an interpretive, methodology. In collating and analysing documents I am therefore focusing primarily on the contents of documents, what the documents actually say about the use of feedback from patients. But at the same time, it is not simply what the documents say about the use of

feedback that it of interest. The ways in which the documents themselves are actually used, by Trust Boards and by managers more generally, are themselves important sources of information about the use of patient feedback.

There are many issues that have to be addressed in focusing on the contents of documents as sources of data in social research. Some of these issues are concerned with the relationships between documents and other sources of data. Some researchers sometimes appear to treat the contents of documents as subsidiary sources of data, to be used to fill gaps that cannot easily be filled in other ways: 'For case studies, the most important use of documents is to corroborate and augment evidence from other sources.' Yin (2009, page 103). Documents are particularly useful in providing evidence about historical events for which observational or interview data are not available; this aspect of documentary data was important for me in finding out about events and actions both before and after my main period of data collection in 2011. Documents also often contain large amounts of detailed information that are simply not held in the minds of individual people; the contents of reports about the collection of different kinds of patient feedback and the contents of reports containing the detailed results of surveys and other kinds of feedback are examples which I have used extensively in this study.

This is not to argue that the contents of documents, even when considered in isolation, should be taken at face value. Shaw et al. (2004) have shown in the case of health policy documents that the contents and meanings of these documents can be interpreted at three levels: the overt or explicit meaning of the information contained in the documents; the rhetoric of the document that is intended to shape or influence the reader's interpretation of the contents; and the (usually implicit) ideology and beliefs that underpin policy. Although Shaw et al. examined government policy documents which have explicit aims of influencing people and events in the future, the same approach can be taken to other kinds of documents that are used in the provision and management of health services, or in management more generally. Without focusing the research primarily on the meanings and interpretations of documents, I have nevertheless identified different elements of empirical, rhetorical and ideological content of documents and used these differences, especially in Chapter 4, to analyse the ways in which feedback is used to 'improve' services and to uncover the criteria and standards that are implicit in the use of feedback.

As part of my work to familiarise myself with government policy about the collection and use of patient feedback, I read the legislation and a wide range of public policy documents published since 1997 that either set the policy context for patient

feedback or were more directly about feedback itself. I identified about 110 documents (including Acts of Parliament, Regulations, government white papers and policy, Department of Health guidance, and guidance and other documents produced by Monitor, the Care Quality Commission or other bodies) that contained some material directly about patient feedback. I systematically examined these documents electronically (by using search terms for patient feedback or different kinds of feedback: 'feedback', 'complain', 'comment', 'compliment', 'survey' and 'view') in order to identify those that contained significant policy or information about the use of feedback. As a result I identified 10 pieces of legislation, 12 DH policy or guidance documents, six Monitor documents, and three Care Quality Commission documents and five CQC survey reports, which I have used as evidence or indirectly in the preparation of this thesis. I list these documents in Appendix 4.

The central government and regulatory body documents I used in this research may be expected to display to different degrees and in different ways the empirical, rhetorical and ideological characteristics identified by Shaw et al. (2004). Legislation in the form of Acts of Parliament and Regulations does not aim to provide empirical descriptions of the world; but in authorising or prohibiting specific activities it does provide information about those activities. Although legislation is not overtly rhetorical or ideological in its content, it does necessarily reflect the (implicit) views of policy-makers and Parliament about what should or should not happen in society. I have used specific pieces of legislation (especially the Regulated Activities Regulations of 2010) to help identify in Chapter 4 some of the ideology relating for example to risk and safety that underlie much recent Government policy relating to the use of patient feedback. Shaw et al. focused in their analysis on formal government policy documents; I have used not only government policy documents and white papers, but also Department of Health guidance to the NHS, DH official letters to NHS organisations, and guidance, codes of governance and compliance frameworks issued by the Care Quality Commission and Monitor as regulatory bodies. These form a substantial body of documentation that is sometimes concerned to describe and disseminate good practice but is more often intended to tell the recipients what they should be doing. The documents are thus not only sources of evidence about rhetoric and ideology; they also explicitly or implicitly identify or describe different uses of feedback, providing additional evidence about how feedback may actually be used in the management of services.

Many of the documentary sources from Trusts that I have listed in Appendix 5 have the same characteristics as central government documents. The

questionnaires, coding frames and statistical reports produced by and used in Trusts are not themselves descriptions of the uses of feedback but, like Care Quality Commission surveys and reports, they do contain a great deal of important information about patient feedback and hence about the use of that feedback. They also contain implicit information about the beliefs and ideology that underpin the use of patient feedback in the Trusts. Comparison of national and local questionnaires helps reveal what is considered important locally. Analysis of benchmarks and the reporting and colour-coding of results reveals not only the empirical facts about the survey results but also the perceptual framework through which the managers who designed the reports and used (or did not use) the results thought about patient feedback. The analysis of these documents may not focus on ideology in a specifically political sense, but it does help reveal something of the assumptions and beliefs that are built into everyday practice in the use of feedback and hence about 'improvement' and the management of services more generally.

Beyond this initial group, the documents I have listed in Appendix 5 are very varied in their nature and reveal a variety of different kinds of empirical, rhetorical and ideological material about the use of patient feedback. Annual Plans, Quality Accounts, the Annual Reports of Committees and Chief Executives' Reports to Boards of Directors all at one level contain factual information about current uses of patient feedback. They also contain invaluable information about the large array of other priorities and initiatives on which Trusts are working, thus helping, without this being their explicit purpose, to identify the context in which feedback from patients is collected and used. But these documents are also all intended for public or quasi-public consumption. They contain 'good news' that presents the Trusts in a positive light and statements of intent about what the Trusts want to achieve; these statements provide information about the use of feedback but may not be full accounts of what actually happens at present. Performance reports, quality reports and patient experience reports, being based on surveys, statistics and other numerical data, are like the surveys themselves capable of being analysed to identify in-built assumptions about the nature and use of feedback. They also often contain explicit statements about standards of service and what needs to be done to improve services, and are therefore explicit sources of information about how feedback will be used. This is a major part of my analysis in Chapters 4 and 6.

3.4.5 Completion of Fieldwork

During fieldwork in 2011, I assessed progress with data collection and made decisions about the completion of fieldwork in the context of coverage in data collection of organisational roles and processes, the coverage and adequacy of data about the four examples (neuroscience, cancer, food and feeding, and out-patient improvement) of the use of feedback, and practicalities of time-scale for the research as a whole (Bryman 2008, Bowling 2009).

The purposive sampling for the study focused on identifying interviewees in a variety of management roles in the Trusts in order to ensure that data about the collection and use of feedback did not simply reflect the views of a single set of occupational or professional roles. In terms of organisational structures I decided to focus on four main levels: board of directors; corporate managers; divisional or directorate managers; and individual clinical or non-clinical services. Towards the end of fieldwork I decided also to interview individual governors of the Trusts. In terms of professional or managerial roles, I decided to include not only full-time managers but also of staff with clinical professional roles who were also involved in the management of services. The coverage of managerial roles was shown in Table 4.1. Because I did not have access to any published or other information about the distribution of managerial and professional roles in the Trusts, I assessed the completeness of coverage of roles during fieldwork using the records in the fieldwork log as an indicator that I had at least interviewed (or in the case of non-executive directors observed) some managers in each Trust at each of the main broad roles which I had initially intended.

Coverage of organisational processes was assessed in terms of the annual planning cycle, ensuring that data were collected at the time of the preparation of an annual plan containing strategies for service development and resource use, the in-year management of services and resources, and year-end reporting. Because of the practicalities of the timing of fieldwork, data were collected not about the whole of a single cycle but about events in calendar year 2011: year-end reporting for 2010/11; annual planning for 2011/12; and in-year management for the last three months of 2010/11 and the first nine months of 2011/12. These aspects of coverage meant that fieldwork focused on actions and interactions at board level, between corporate directors and service directorates, and between corporate and service directorates and individual clinical and non-clinical services, giving coverage of major processes and relationships in each Trust as a whole.

Coverage of organisational roles and processes merged in some respects into issues of coverage and adequacy of data about the four examples of the use of feedback on which I was focusing. By the autumn of 2011 I had interviewed four of the managers with the main responsibilities for the food and feeding initiative at Hillside and four with responsibility for the out-patient initiative at Northbank, in addition to asking other corporate managers, directors and governors about these initiatives. By the autumn I had also interviewed seven managers about neurosciences at Hillside and ten about cancer services at Northbank. These interviews, with documents at and observation of relevant discussion at Board of Directors meetings (three for out-patient improvement and one each for food and feeding, neurosciences and cancer services, plus the associated papers and minutes of the meetings), and with additional data from routine Board Reports, Annual Plans and Quality Accounts, provided a substantial amount of data about each example for analysis.

The final influence on the scale and duration of fieldwork was the length of time available and the amount of data collection that could be undertaken to fit in with the overall timetable of the research and completion of the thesis. Although I could have continued to collect more data about some issues (such as the use of patient feedback in the formal performance management processes at directorate and service management levels within the Trusts, or the ways in which complaints and other forms of feedback are used in disciplinary proceedings against staff), it appeared by the end of 2011 that the overall balance between coverage of organisational roles, the coverage of a full annual cycle of business management and the description of the collection and use of feedback in specific examples had provided sufficient data of sufficient quality to justify moving from fieldwork to analysis of data and drafting of findings.

3.5 Data Processing, Coding and Analysis

'Thematic analysis' (Pope et al. 2006) is the simplest form of data analysis in qualitative research. The data are grouped into themes; the data and the themes are then re-examined to make sure all the manifestations of each theme are accounted for. Exploratory research studies may simply report the results of this classification and analysis. More complex studies examine the inter-relationships between themes. The additional complexity may be reflected in additional layers of coding (Miles and Huberman 1994) and additional methods of analysing the data and presenting the findings (Ritchie and Spencer 1994). In my data processing and analysis I have

followed the strategy laid out by Pope et al. but also draw at specific points on the methods described by Miles and Huberman and the framework analysis of Ritchie and Spencer.

3.5.1 Data Processing and Storage

My first data processing task, undertaken both during and at the end of fieldwork was preparation and storage of the three kinds of data, interviews, observation notes, and electronic and paper copies of documents. During and after fieldwork the audio-recorded interviews were transcribed, about half by myself and half by a professional typist. I then checked all the transcripts against the original recording, where possible filled any gaps and if necessary corrected any errors in transcription. The audio recordings were retained in case they were needed for further checking of the transcription and as a record of the data collected. Each interview transcript was then filed for analysis. I transcribed all my hand-written observation notes of meetings, eliminated obvious errors in my note taking, and filed the transcripts as data for analysis. I also retained the hand-written notes as part of the record of data collection. I collated and filed electronic copies of the government documents I had collected before and during fieldwork and Trust documents collected during and after the main period of fieldwork in 2011. I also separately collated and filed paper copies of documents that I had been given during fieldwork. Although the government and Trust documents, taken with the interviews and observations, formed a substantial volume of material, I did not at this stage put on one side or discard any of the data.

On the completion of fieldwork, all the data (with the exception of one set of board papers and a small number of other documents that had been made available in paper format in interviews) were assembled, filed and stored electronically. Separate folders were created for data from each hospital in the study, and then within each hospital's folder, sub-folders for five main sets of data:

- interview transcripts;
- observation notes from Boards of Directors and performance review meetings;
- agendas and papers from the Board of Directors meetings;
- documents prepared by the Trust's managers or downloaded from the public parts of the Trust's website (including for example annual plans and annual reports, complaints and PALS policies and

procedures, patient and public involvement strategies, staff commendation scheme); and

- documents and data about the Trust but prepared by other organisations (e.g. the Strategic Health Authority, the Care Quality Commission).

The data folders were then imported into NVivo 9 to facilitate the coding and analysis of the qualitative textual data.

3.5.2 Initial Analysis

Within this strategy preliminary analysis of the data proceeded in stages. Bryman (2008) and other authors consider that there is not a single set of rules for the effective analysis of qualitative data. Ritchie and Spencer (1994 page 177) suggest a framework approach: a series of iterative steps in variable order, sifting, charting and sorting material according to key issues and themes. They also emphasise the importance of the first stages of analysis: familiarisation – immersion in the range and depth of the data; and identifying a thematic framework, key issues, themes and concepts from a priori issues and the research aims. My preliminary analysis was undertaken in four main stages: initial reading and annotation of interview transcripts, observation notes and documents; preparation of informal working papers exploring the relationships between theoretical issues and empirical data; development and testing of an initial coding frame; and revision and development of the final coding frame.

Taken together the electronic files and paper copies of documents formed the data available for analysis. I had begun the task of familiarising myself with documentary data before the start of fieldwork proper in 2011. In 2010 I read and annotated Department of Health policy documents, from the 1997 The New NHS white paper onwards, and the web pages, annual plans and annual reports of Hillside and Northbank Hospitals. During fieldwork I continued to collect and read Trust documents, especially the papers of all the regular Board meetings. I also became increasingly familiar, through attending meetings, reading papers and interviewing and talking to managers, with many aspects of the collection and use of feedback, with some of the managers and clinical staff in the Trusts, and with the work and priorities of the two Trusts more broadly. After the end of fieldwork, I systematically familiarised myself with the interview and observational data, by reading the interview transcripts and observation notes, and by making notes of themes for subsequent analysis. Although some of this material helped me become familiar with the Trusts

and the ways in which feedback was used, I have not directly used it in the writing of this thesis. I have nevertheless retained it for the record and for possible further analysis in future.

3.5.3 Thematic Coding and Analysis: Interviews and Observation

In the first stages of familiarisation and preliminary analysis of my data, my attention focused both on specific questions about the collection and use of patient feedback that I had asked interviewees and on broader issues about the influence of government targets and priorities and markets, choice and consumerism in health care on the use of patient feedback. In my initial analysis of the collection and use of feedback I began trial coding of the interview data, focusing first on three main interview questions that reflected the overall purpose of the study and the published research literature. The three questions related to: the different kinds of patient feedback that were collected in the Trusts; examples of the use made of patient feedback; and the aims of collecting and using patient feedback. These three topics, the kinds, uses and aims of feedback, formed the beginnings of my thematic analysis.

During my subsequent detailed coding and analysis of the data, the detailed coding and thematic analysis developed iteratively with each other. Closer examination of detailed data led to the identification of new themes; the identification and analysis of new themes led to more detailed examination and coding of data. I will focus first on the detailed coding of my data; I will then focus on the thematic analysis; and finally return to questions of detailed coding. My detailed coding of the data was based primarily on the interview transcripts in part because the interview questions addressed specific research questions very directly and therefore directly provided a large amount of detailed material for coding and analysis.

The three interview questions about the kinds, uses and aims of patient feedback provided me with an initial thematic framework within which to begin coding the interview data. I first read all the answers to these interview questions and from the answers at the time of reading identified a set of codes (labels in the terms of Pope et al. (2006); indexes in terms of Ritchie and Spencer (1994)) in NVivo for the relevant extracts. As I created the codes I also made brief guides for myself to say what I meant by each code and help me code data consistently later. Having created this preliminary set of codes, I then re-read the material that I had coded in them and as a result revised some of the codes and some of the coding of the data. I then re-read the interview transcripts and identified and coded additional material from elsewhere in the interviews that directly added to the material on the kinds, uses and

aims of feedback. I shared the coding frame and examples of the coded interviews with my supervisors, to test and develop the accuracy of the coding. We discussed some of the overlaps and difficulties of discretely coding much of the data, and the possibility of having completely clear and rigorous definitions for each code. As a result I revised some of my guidelines so that they were more explicit about where there were overlaps and uncertainties in coding. The results of this work formed the initial codes and generated much of the coded data that I have subsequently used in the analysis.

Although the texts on qualitative research methods say that it is the theoretical relevance of codes rather than the number of pieces of data that are coded in particular ways that is important for the analysis of data, I found it impossible to ignore the frequency with which particular codes appeared in my interview and observational data. Frequency, while not indicative of representativeness, did seem to indicate importance, importance to the interviewees and, potentially, importance in the research. At this initial stage of coding it became clear that I had a great deal of data about feedback through complaints, surveys and PALS but virtually none, however interesting it might have been theoretically, about feedback through MPs, legal cases, or changes in referral patterns. Similarly, I had a great deal of data about the use of feedback to improve services and to influence staff, but very little about its use in quality assurance or business planning. While it is important to report negative findings and the absence of positive findings, the primary focus of this research on examining how feedback is actually used in the management of services has led me to concentrate on those areas about which I have most data.

The initial coding of data about the sources, uses and aims of feedback, when taken alongside some of findings in the published research literature, began to suggest additional themes for analysis. These additional themes correspond to the 'axial codes' of Miles and Huberman (1994). Interviewees and documents often talked about the purpose of patient feedback as being to improve patient experience, to make things better for patients, or to improve health care. As a result I focused on data about these issues, developing both a broad analytical theme and a detailed coding structure relating to it; this focus prompted me to return to the research literature about patient feedback to see what it said about 'improvement' and hence to develop one of the main themes of this thesis. Interviewees often talked at considerable length about the organisational processes through which feedback was collected, analysed and used in Trusts; as a result I coded this material, some (but not all) of which subsequently formed the basis for the detailed results and analysis

about Boards of Directors that are also presented in this thesis. Equally importantly, some of the details of the coded data began to suggest analytical themes that were not mentioned at all in the published research literature about patient feedback. Interviewees, Trust documents and observational data all talked, in a variety of different contexts and a variety of different ways about feedback about staff and about the use of feedback to influence staff. These data similarly form the basis of Chapter 5 in this thesis.

As a result of this work the coding framework as finalised for data analysis reflects five main themes or domains:

- the kinds or sources of patient feedback;
- the domains of patient feedback;
- the uses of patient feedback;
- the aims of using patient feedback; and
- the organisational processes in the use of feedback.

These five themes provide the framework within which I undertook the more detailed coding of data. They also formed the starting point for the further development of the concepts on which the analysis and findings presented in this thesis are based.

As well as developing these thematic codes I needed a way of identifying and analysing data about each of the four examples of the use of feedback, in neurosciences and the food and feeding initiative at Hillside Hospital and in cancer services and the out-patient improvement initiative at Northbank Hospitals. I began by coding all the data from interviews in these four categories, but quickly found that I had so much varied data about cancer services that I decided, rather than coding every mention of cancer under a single broad heading, only to focus my attention on two specific themes that had been identified in fieldwork: the 2010 national cancer patient survey and the development of a new chemotherapy day unit. I subsequently coded interview and observational data under these headings so that I then had a framework through which I could examine the relationships between the thematic codes I had developed earlier and these four examples.

Appendix 6 shows the detailed coding framework I used in coding all the interview and observational data presented here. Having developed the coding framework into its final form I then used it to code the interviews and observational data contained in my notes of meetings the meetings I had observed. The coding of these observation notes resulted in a narrower range of less detailed coded data than the coding of the interviews, especially about specific uses made of patient feedback.

Although I initially felt that this lack of detail in the observational data might reflect a weakness in my observational and recording methods, I later came to consider that, when taken with the related interview data, the lack of specificity in the observational data was in itself saying something important about how managers did or did not actually use patient feedback. This realisation then served as a starting point for my analysis and findings about boards of directors in Sections 6.3 and 6.4 in Chapter 6.

All the data were originally collated and coded in NVivo 9 and subsequently transferred into NVivo 10. During coding and preliminary analysis I developed within some of the themes sets of main codes and sub-codes (parent and child nodes in NVivo) reflecting my focus on particular topics and the amount of detail in the particular area. In coding material about the use of patient feedback to influence staff I initially had created one code for influencing staff generally and additional codes for praising and for performance managing staff. As I examined the material in more detail I came to identify 10 or more different ways in which feedback was used to influence staff and decided to create a series of sub-codes within the main 'Staff' code. Similarly, as my analysis of the aims of using feedback deepened, I came to see a distinction between feedback that reflected patients' subjective, emotional experience of their illness and experience in hospital and feedback about the services themselves. This distinction, which is not clearly drawn in much of the research literature (but see for example Entwistle et al. 20112), was then reflected in the development of more specific codes and the re-coding of the data and subsequently formed the starting point of my analysis and findings in Chapter 4.

In developing the detailed codes and using the framework in coding the interviews and my observation notes I also developed a coding guide for each code to help maintain consistency in coding. Although I began coding with the intention of producing precise definitions of each code, to support the aims of clarity, consistency and avoiding overlap between codes, I found this to be impracticable and considered it would potentially be counter-productive in terms of the broad aim of the research. The impracticability arose from the ways in which all my data sources – interviews, documents and observations – generated data that themselves did not distinguish between potentially differentiable phenomena and in fact often made direct use of overlaps between related ideas. Thus, for example, interviewees talked in a single phrase about staff attitude, behaviour and communication as one domain of feedback; staff and documents talked about communication of information. Similarly interviewees talked about staff 'learning' and training and education without distinguishing between them. In developing the coding and analysing the data I have

therefore used broad groupings of concepts and codes, which may themselves sometimes have uncertainties or overlap at their boundaries, with the aim of mapping out the broad ways in which feedback is used in the management of services and in the knowledge that further research would be needed to develop more detailed conceptual clarity.

3.5.4 Analysis of Documents

In planning to analyse my data, my original intention was to code and analyse the variety of documents I had collected in NVivo, in the same way as my interview and observational data. I began to do this with an initial selection of government policy and DH guidance documents and with Trust annual plans and performance reports, but encountered two sets of difficulties.

The main difficulty with government policy papers and similar Trust strategy papers and Board reports was that the process of selection and coding of specific pieces of text deprived that text of much of its meaning. I found that many of the documents contained so much scattered material directly or indirectly about patient feedback that simply identifying and coding extracts did not provide a clear understanding of the overall shape and contents of the documents in relation to patient feedback. Thus for example the coding of a piece of text from DH guidance saying that Trusts should collect real-time feedback and take rapid action makes greatest sense when read in the context of the DH view that commissioners of health care will want to collect feedback that influences what services are provided and that providers should be concerned with patients' experience of and satisfaction with that health care. I needed a fuller understanding and analysis of the purpose of documents and the context of the specific pieces of text. More information about the context would help me understand the text, in the terms of the stated aims of the document and in terms of the analysis of Shaw et al. (2004) of the empirical, rhetorical, and ideological contents of policy documents. In addition to examining specific coded pieces of text as data, I wanted in my analysis to be able to understand and display fuller information about the background, nature and contents of each document as a whole.

The main difficulty with many of the Board reports and other Trust documents that I began to code lay not in the understanding and analysis of the documents but in the layout and formatting of them. At both Trusts many Board reports, which were my main source of documentary data, were written not in paragraphs in Word based documents but as text boxes or columns inserted in longer documents, in PowerPoint

or as Excel spreadsheets. The process of selection of pieces of text in which I was interested sometimes failed because the text had been inserted as part of a larger, single object in the Board paper. The process of importing and coding the text in NVivo often destroyed the formatting and made the text impossible to read and understand without reformatting it manually by re-reading it in the original document. I found the coding of these documents in NVivo impracticable.

As a result of these two very different sets of difficulties I decided to develop and use different methods of systematically analysing the documents I needed to use for this thesis. I adopted slightly different procedures for the government policy and DH guidance documents and for the Trust papers that I planned to use.

In my initial reading and data preparation for the study I had identified more than 100 documents (including legislation, government policy white papers and Department of Health guidance) published since 1997 that were relevant to the collection and use of patient feedback. I searched these documents electronically, using search terms based on 'feedback', 'complain', 'comment', 'compliment', 'survey' and 'view', to identify material relating to the definition, collection or use of patient feedback. I then listed out all the references and page numbers with brief notes identifying the kinds of feedback that were mentioned and the broad aim or purpose of the legislation or policy. I used this list as the starting point for a detailed working paper that brought out in conceptual terms the context and contents of patient feedback. I then electronically selected and copied into the working paper extracts from the original document that had most relevance to my understanding of the collection and use of feedback. This provided me with a large amount of partly analysed material that I then could use in the thematic analyses that I was developing in working papers based on my coded interview and observational data. These themes related to the use of feedback to improve services, to the use of feedback to influence staff and to the use of feedback by boards of directors in quality assurance and the governance of trusts. I first simply identified all the contextual material, quotes and commentary material in the government policy working paper that was relevant to each of the thematic analyses – a task equivalent to coding in NVivo – and then copied and pasted all that material into the drafts of each of the thematic working papers. This provided me with a set of very long working papers containing thematically organised data from government policy documents to form the starting point of the findings chapters in this thesis. I then further analysed, reviewed and revised this pasted material, integrating the data from the policy documents with my other data as I further developed each of the findings chapters.

In my analysis of Trust documents. I followed a path that was similar but not identical to my analysis of government policy documents. Before and during my main period of fieldwork I accessed and read the main sets of documents in each Trust that were made available on the Trust's public web pages and through meetings in public of the Boards of Directors. In Appendix 5 I identify the different ways in which I used these documents. Some I read and simply used as background information that helped me understand the context of the ways in which patient feedback was used in the Trusts. Others provided me with detailed technical information about the collection, processing or analysis of patient feedback; this information was invaluable in helping me understand how feedback was used but did not generate evidence I have used directly in the preparation of this thesis. Yet other documents were the Board papers and web pages that I have analysed and used directly as evidence in this thesis.

Having previously familiarised myself with Board papers and web pages and having observed meetings of the Boards of Directors, I began a systematic analysis of the Board papers by identifying and listing all the Board papers from meetings in public in 2011. I identified those papers (Patient Experience Reports, Performance Reports and Scorecards) that always contained information based on feedback from patients. I also identified reports that in one or other Trust regularly contained information about or based on patient feedback. This group of reports consisted at Hillside Hospital of the Chief Executive's Report, Transformation Programme reports, Quality Focus Report, Annual Plan and Quality Accounts; at Northbank Hospitals it consisted of the Quality and Safety Report, Annual Plan, Quality Accounts, the Patient Experience and Quality Strategy and Clinical Service Presentations. I then searched all these documents electronically (again using the search terms 'feedback', 'complain', 'comment', 'compliment', 'survey' and 'view') to identify material about patient feedback and prepared a very detailed working paper that summarised what each document said about patient feedback and that included copied and pasted extracts from the documents. This working paper thus became the repository of data I had identified from Trust Board papers about patient feedback.

My next step with the analysis of all the Trust documents – the web pages as well as the Board of Directors' papers and other public documents – as with the government policy papers was to link this documentary material to the thematic analysis that I had developed in the coding of interview and observational data. The thematic analyses were contained in working papers that now served as the basis for the chapters being drafted for this thesis on the use of feedback to improve services,

the use of feedback to influence staff and the use of feedback by Boards of Directors. For the draft of each thematic chapter I first identified and then pasted and copied into the relevant sections of each draft all the relevant material from the Trust documents that I had collated in the previous working paper. As with the government policy material this process was the equivalent of coding in NVivo. It provided me with sets of data that I could then examine and analyse more closely, alongside the coded interview and observational data, in the next stages of the analysis and drafting of the findings chapters.

3.5.5 Integration and Relational Analysis

At this stage of the analysis I had accumulated systematic sets of data in NVivo and text from documents organised under the main thematic codes in which I was interested. These main themes related to the use of feedback in the improvement of the quality of care and services, the use of feedback to motivate and manage staff, and the use of feedback by Boards of Directors in quality assurance and the governance of Trusts. My next tasks were to deepen the analysis of the data and to identify relationships between these main themes and other material in my data (Ritchie and Spencer 1994). There were three main components of my additional analysis

In the coding frame in Appendix 6 I have identified the five domains in which I coded my data and the main codes I used within these domains. After coding and assembling my data I examined it in more detail, inductively identifying different aspects of the phenomena and developing new codes to reflect them. Two of these sets of more detailed codes, relating to patient-related aims of using patient feedback and to using feedback to influence staff, were particularly important for my subsequent analysis. In examining what interviewees said about using feedback to make things better for patients or to improve patient experience, I came to realise that, although they were sometimes using these words in a rhetorical way – as a statement of a desirable objective that justified subsequent actions – they also sometimes used them with more subtle shades of meaning. Looking at the data that I had originally coded as ‘improvements for patients’ I then came to distinguish between for example ‘improving services for patients’, ‘patient experience of services’ and ‘patients’ subjective feelings’. Interviewees might or might not always have made the distinctions that I have drawn on the basis of the words they actually used, but given that their words were the data with which I was working, my analysis of these distinctions forms the basis of parts of the findings in Chapters 4 and 5. Similarly my

initial coding of the use of feedback to influence staff was a very broad category. As my interest in the staff theme developed I examined the data more closely and came to identify the variety of different ways in which managers used feedback to motivate, train and manage staff. I recoded the data to reflect these differences. These different uses of feedback are also reflected in final coding frame and serve as the basis for the findings in Chapter 5.

In addition to seeking and finding more detail in my data, in developing the analysis I also looked for broader sets of relationships between the main sets of coded and documentary data, the connecting strategies between the different segments of data (Ritchie and Spencer 1994, Maxwell 2012). The initial steps in this analysis of relationships consisted of an attempt to use the interview data coded in NVivo to identify systematically and comprehensively the relationships between different kinds of feedback, different domains of feedback and different uses of feedback. This attempt resulted in a large, rather sparsely populated set of cross-tabulations that did not appear to be telling me very much about how different kinds of feedback were actually used. I therefore began to look more selectively, within the analytical themes I was developing, at the relationships between different sets of coded and documentary data. In analysing the data I had collated about improving services, for example, I examined the relationship in NVivo between interview data coded as using feedback to improve services and data coded as the aim of using feedback to improve patients' subjective experience and then looked to see whether these differences and relationships were reflected in the Quality Accounts, Quality Reports and Performance Reports presented to Boards of Directors. In analysing the data about the use of feedback to influence staff, I examined all the data that I had coded as 'Staff' and then identified that different sources and different domains of feedback that had been used in any way to influence staff. Similarly in analysing documentary and observational data about the use of feedback by Boards of Directors, I went back not only to the material coded in NVivo as Boards of Directors but also to the relationships between this material and data coded as uses of feedback. I examined all the data that I had coded as 'boards of directors' and systematically identified all the different uses of patient feedback that I had previously coded in those segments of data. By examining these specific pieces of data that I had coded more than once under different codes, I came to focus on the possible role of Boards in using feedback in the monitoring and quality assurance and in business planning and strategies, analyses that then formed the basis of my findings. In all these examples, the

connections between different codes provided me with the sets of data on which my findings in Chapters 4, 5 and 6 are based.

In Section 3.4 I described how I had collected data and selected interviewees purposively to focus on four examples of the use of feedback, neurosciences and the food and feeding initiative at Hillside Hospital and cancer services and the out-patient improvement initiative at Northbank Hospitals. My first step in analysing data about these examples was to code interview and observational data in NVivo to the relevant example and to identify the relevant documentary data. I began to assemble material and found that interviewees had given me apparently conflicting accounts of the origins of the improvement initiatives and of their roles in them. This was particularly true of the food and feeding and the out-patient improvement initiatives. It led me to ask myself the question 'What actually happened?'. I addressed this question by assembling for each of the four examples the data I had collected from all sources to provide chronological accounts of events. Data relating to specific examples were analysed following the methods outlined for example by de Vaus (2001) and Yin (2009) to build up from multiple sources coherent, time-ordered narratives of events, comparing data derived from the different sources to identify the key factors in each individual example. My framework for analysis consisted of a focus on specific actions and events, the organisational processes through which they occurred and the context in which they occurred (Miles and Huberman 1994, Pawson and Tilley 1997). I initially wrote up these accounts in working papers with the idea of presenting them as mini case studies in their own right. But these mini case studies, while containing much interesting detail, did not contribute substantially to the thematic analysis I was developing for this thesis. I therefore revised the material that I had drafted and went back to my original sets of interview, observational and documentary data to re-frame the four examples in the context of the analytical themes. My aim in this has been to develop and test the thematic analyses in my findings chapters by using detailed data about each of the four examples in their particular settings. In Chapter 4 I examine what the response by Northbank Hospitals Trust to the 2010 national cancer patient survey and the food and feeding initiative at Hillside Hospital tell us about the ways in which patient feedback does (or does not) stimulate Trusts to improve services. In Chapter 5 I examine how feedback from neuroscience patients was used at Hillside Hospital in the training and management of staff. And in Chapter 6 I examine not only the ways in which feedback from patients was used by in the development of the out-patient initiative at Northbank Hospitals but also the limitations in the ways in which it was used by the Board of Directors. In this way I aim to integrate detailed data in

each of the examples with the general thematic analyses in each of my findings chapters.

Chapter 4 The Use of Patient Feedback: Improving Hospital Services

4.1 Introduction

I argued in Chapter 2 that the empirical research literature about patient feedback often assumes that the purpose of collecting and using feedback from patients is to improve services, but that the literature contains little analysis of what is meant by 'improvement' and little analysis of other uses of feedback. The purpose of this chapter is to examine more systematically the ways in which different kinds of feedback from patients are used to improve services. I focus first on the relationship between the use of feedback to improve patients' subjective experience of services and its use to improve the services themselves, and then on the criteria and standards by which managers identify and assess improvement in the services for which they are responsible.

In Sections 4.2 and 4.3 I examine two contrasting uses of patient feedback: the use of feedback to improve patients' subjective experience of services; and the use of feedback to improve the quality and delivery of services as defined by service providers and managers. Section 4.4 examines the relationship between these two uses of feedback, in order to examine how managers actually use feedback. Section 4.5 analyses the measurement and reporting of patient feedback in Trusts' formal reports; it examines whether the format and content of these reports themselves influence the ways in which feedback is used to improve services. Section 4.6 then analyses two examples of the use of patient feedback – in cancer services at Northbank Hospitals and in the food and feeding initiative at Hillside Hospital – to examine how different kinds of feedback are used in a practical context to improve patient experience and services for patients.

4.2 Improving Patient Experience

In Chapter 2 I framed the initial definition of patient feedback as being about patients' use of health services and their experience of health services. This definition was intended to include in the study both feedback that reflected patients' feelings and subjective experience while they were using health services and the information they provided about the services themselves. I also argued that most of the empirical patient feedback research literature focuses not so much on patients' subjective experience as on specific domains of health care or health services. My aim in this

section is to examine the ways in which feedback from patients is used to improve the subjective experience of patients.

In this section I draw on two main sources of data, Department of Health guidance and other national policy documents, and interviews with managers at Hillside and Northbank Hospitals. The DH policy documents often use terms like patient experience and patient satisfaction without being clear about their exact meaning. Similarly, the Darzi Report (Department of Health 2008b) (while being presented as an NHS review rather than a Department of Health document) focused quite extensively on patient experience but did not define it at all clearly. Interviewees, as I will show, provide more descriptive detail and commentary that highlight the subjective nature of patients' experience and that, on occasion, identify quite radical implications for the way in which that feedback should be used.

Department of Health guidance suggests that one of the aims of collecting and using patient feedback is to improve patients' experience of and satisfaction with services. The NHS Plan of 2000 (Department of Health 2000, page 93) said that all NHS trusts would have to ask patients for their views on the services they had received. Guidance issued about the implementation of the Health and Social Care Act 2001 quoted the Department of Health's Priorities and Planning Framework for 2003 to 2006:

"The NHS will be transformed through better engagement with patients, the public and staff. By regularly seeking out and acting on local feedback, the NHS will create patient responsive services that people perceive are improving. " (Department of Health (2003)

Strengthening Accountability, Policy Guidance, page 4)

Here the focus is on feedback as a way of influencing patients' perceptions of improvement in health services. The point I wish to highlight is the distinction in the guidance between improvements in services and patients' perceptions of improvements in services. The policy objective is not only to improve services; it is also to improve people's perceptions of services.

Later guidance focused more explicitly on patients' experience of services. The Department of Health issued in 2009 'Understanding What Matters: A Guide to Using Patient Feedback to Transform Services' (Department of Health 2009b). The Introduction distinguished between individual feedback from patients about 'the quality of care that they have experienced, their needs and preferences' and 'collective perceptions from the public: obtaining intelligence on what matters to local populations.' (page 5):

“This guide focuses on measures of experience which ask patients about their own experiences in receiving care and treatment, reported immediately or shortly after the episode of care.” (Department of Health (2009b) *Understanding What Matters*, page 5)

Feedback by implication consists of information about patients’ own experiences of treatment and care. The purpose of feedback is improvement.

“There is a growing interest from NHS providers working in hospital and community settings and from PCTs in collecting information from patients and service users in as near to real time as possible. This is so that results can be assessed quickly. This approach offers a clear opportunity for the NHS to make improvements.” (Department of Health (2009b) *Understanding What Matters*, page 7)

Commissioners and providers will use feedback for different purposes. Commissioners will use feedback to inform commissioning decisions and contract management. Feedback ‘will help to demonstrate that they are providing the right services, at the right time, with the right outcomes for patients.’ (Department of Health 2009b, page 8).

“Providers aim to deliver high-quality services that provide excellent experiences for patients and service users. They are focused on meeting the needs of patients. They will want to know whether patients are satisfied with the care they have received and whether they would recommend the hospital to others. They will recognise that real-time techniques allow them to collect information quickly and take rapid action.” (Department of Health (2009b) *Understanding What Matters*, page 9)

For providers the concept of feedback is quite specific: it is generated at the point of care; it is about patient experience and patient satisfaction; and it should be used immediately to improve the quality of care for patients. In framing the objectives in this way, the guidance distinguishes between on the one hand ‘patient experience’ and on the other hand ‘high-quality services. The purpose of collecting feedback about patient experience is, in this guidance, to improve the quality of services.

For many managers the purpose of collecting and using feedback from patients is to improve patient experience. Managers were asked in interview about the aims of collecting feedback from patients. They focused not on improving services

or the quality of services but on patient experience. The primary aim of collecting and using patient feedback is for many managers to improve patient experience itself.

“Well what we’re trying to achieve very clearly is a much better experience for patients in this hospital, and there’s absolutely no doubt about that.” (Corporate Director WT, Hillside Hospital)

The reason for using patient feedback:

“So ultimately the patient has a better experience of course.”
(Corporate Manager MG, Northbank Hospitals)

And again

“Well I really believe that they’re trying to improve the patient experience. And yes, and basically and using that feedback to help us do it essentially.” (Consultant Physician RG, Northbank Hospitals)

For these and other managers the basic purpose of collecting and using patient feedback is to improve patient experience. In using the phrase ‘patient experience’ in this way, these managers appear to draw a distinction between improving services and improving patient experience. Their focus in talking about the use of feedback is on improving the subjective experience of patients, as distinct from improving services for the benefit of patients.

The phrase ‘patient experience’ in the examples quoted above, does not refer directly and explicitly to the subject matter of that experience, the domains of experience or feedback. The emphasis is to some extent on the subjective aspects of experience, what patients think and feel, as distinct from the objects (for example treatment, care or services) about which they are thinking or which influence their feelings. Managers talked about the use of patient feedback to improve patient experience in terms of patients’ subjective experience and feelings, and the importance of staff understanding those subjective feelings. Consultant physician RG said in interview that the aim of using patient feedback was to improve patient experience. She was asked what she meant by patient experience.

“Just the fact that when the patient comes in here, you know, they’re very stressed with their cancer diagnosis and the fact that you want to make it as sort of pleasant and organised for them as possible. ... You know it’s the nursing staff informing them that the clinics may be running late, all that kind of thing. So they know where they are and they don’t feel stressed and frightened by the, yes, not knowing what’s going on.” (Consultant Physician RG, Northbank Hospitals)

The emphasis here is on patient experience as uncertainty, stress and fear. Feedback helps clinicians and managers reduce uncertainty, stress and fear. But patient experience is also about the positive side of patients' feelings.

"So I think that it's a broad aim that all patients have a positive experience. ... It's the softer, it's not just about the clinical outcome, it's about how they feel when they're here, and they feel safe and they feel that people care about them ... So that we see the kind of whole holistic, the whole picture of the patient, see them as individuals." (Directorate Manager ZS, Northbank Hospitals)

In both examples the managers' primary focus is on how patients feel while they are in hospital, how they feel about their illness and the treatment and care they are receiving. Patients' feelings and emotions, as well as their perceptions, are in this view the core of patient experience. The focus for managers then becomes one of what feedback reveals about these feelings and perceptions. The purpose of feedback is to enable service providers to limit negative experience and increase positive experience. The view of these managers that the aim of using patient feedback is to improve the subjective experience of patients per se thus differs from the view expressed in DH policy and guidance that the purpose of collecting and using feedback about the experience of patients is to improve the quality of services.

The focus on the individual and personal elements of patient experience is part of the formal policy and managerial practice at Hillside Hospital. Individual patient stories and complaints are used to deepen the understanding of staff of patients and their circumstances. These stories and complaints are used to strengthen and reinforce the commitment of staff to the well-being of patients. The formal statement of values of Hillside Hospital Trust emphasises the importance of understanding the individual patient:

"Understanding you. We appreciate each person as a unique individual. We start by listening – then act on what we learn."
(Hillside Hospital web page, accessed 7th April 2011)

'In Your Shoes' events at Hillside Hospital were ward-level events in which individual patients met with staff so that the staff heard first-hand what patients felt about what was happening on the ward, not in an environment in which people were being held to account, but in open discussion.

"... but it's just 'I'm telling you how it was for me.' And it's just worth listening to that. We've had consultants moving out of those meetings saying 'You know what, that was extraordinary. That's

reminded me why I came into medicine. That's the first time I've been able to talk to a patient like that in years.' ” (Project Manager KP, Hillside Hospital)

The personal discussion, the level of communication between patients and staff, renewed the motivation of staff, clinicians and managers, about why they worked in the Health Service and what they were trying to achieve. This documentary and interview data suggests that communication with patients was used at a corporate level in Hillside Hospital Trust (but not to the same extent or in the same way at Northbank Hospitals) not only to motivate and manage staff individually but also to help set the tone and guide the management of the Trust more generally, focusing on the circumstances and experience of individual patients.

This focus on the subjective experience of patients is linked directly to the use of feedback in order to find out what patients want and to help meet their wants. Managers were asked about the aims of using feedback.

“I believe that the, especially in the senior team, perhaps particularly our chief nurse, really wants patients to have a positive experience. And staff care about what patients think and they want – so when we hear about something negative, then we want to make it better.”
(Directorate Manager ZS, Northbank Hospitals)

For ZS, there is a quick move from the focus of ‘the senior team’ on ‘patient experience’ to the perhaps more everyday focus of ‘staff’ on ‘what patients think and ... want’. She and other managers see feedback as a way of finding out about and responding to what patients want.

“I think it's about confirmation of what we're doing right and a sort of real feel of what people want, what's really important to people ... “
(Divisional Nurse Manager EW, Hillside Hospital)

“I think it's ensuring that you'll be making changes, the changes that people want and really about driving up quality for them.” (Project Manager NM, Hillside Hospital)

In these comments managers talk about what patients want, but do not talk about what patients want in isolation. EW links what people want with what is really important to them; ZS links what patients think and want. This implies that managers think that patients are making a whole series of judgements about services and what they want from services; the use of services is an interaction between service user and service provider; feedback grows from and is part of that interaction.

Despite the different shades of meaning attached by managers to the notion of patient experience and to the aim of using patient feedback to improve the subjective aspects of patient experience, there is very little clear analysis in government policy or guidance of these aims of using feedback. It is however possible to see a continuing thread in government policy focusing on the subjective aspects of patient experience and on patient satisfaction. One of the aims in the NHS Plan of 2000 was to create services that people perceived were improving. But the Plan did not talk about the relationship between patients' perceptions of improvement and other criteria of improvement. Similarly the Darzi Report (Department of Health 2008b) set patient experience alongside clinical effectiveness and safety as the three components of the quality of health services, but did not examine how these three different elements might interact with each other. The Equity and Excellence white paper (Department of Health 2010) said that providers of health services would want to know whether patients were satisfied with the care they had received and would recommend the hospital to others. In none of the major policy documents was there detailed analysis of the relationship between patient experience and other aspects of the quality of services.

The Darzi Report 'High Quality Care for All' provides the clearest focus on patient experience. The Report '... makes the patient experience a key driver of quality and thus quality improvement.' (Department of Health 2008b, page 3). The quality of services is defined in terms of clinical effectiveness, safety and patient experience. Despite the centrality of the term 'patient experience' to the idea of quality in the Darzi Report and subsequent DH policy and guidance, the Report did not provide a detailed analysis of what it meant by patient experience. The closest it came to a definition of patient experience:

"Patient experience. Quality of care includes quality of caring. This means how personal care is – the compassion, dignity and respect with which patients are treated. It can only be improved by analysing and understanding patient satisfaction with their own experiences."

(Department of Health (2008b) *High Quality Care for All*, page 47)

Despite the lack of grammatical clarity in the phrase 'patient satisfaction with their own experience' (which might possibly reflect a lack of conceptual clarity by the report's authors about the relationship between satisfaction and experience), the implication here is that patient experience is defined as the 'quality of caring', which is in turn defined as 'compassion, dignity and respect'. In these terms patient experience is identified with specific aspects of the interpersonal interactions between staff and

patients during treatment and care. If patient feedback is in turn defined in terms of patient experience, the definition of patient experience offered in the Darzi Report would suggest that the domains of feedback would be restricted to these interpersonal interactions in the provision of care. The criteria and standards of improvement resulting from feedback would be assessed not in terms of staff's 'objective' measures of quality but in terms of patients' perceptions of the attitudes and behaviour of staff. Patients not staff would make the judgements about improvement in quality.

Similarly, the Conservative-led Coalition Government's Equity and Excellence white paper (DH 2010a) repeated and developed some of the earlier principles about the use of patient feedback, but did not add detail or clarity about the ways in which services would be expected or judged to have improved as a result of feedback. The white paper emphasised the importance of patient feedback to help assess the quality and safety of services:

"All sources of feedback, of which complaints are an important part, should be a central mechanism for providers to assess the quality of their services. We want to avoid the experience of Mid-Staffordshire, where patient and staff concerns were continually overlooked while systemic failure in the quality of care went unchecked." (Department of Health (2010) *Equity and Excellence*, page 19)

Current policy is that feedback should be used to assess the quality of services. The underlying aims are the prevention of harm, the reduction of risk and the improvement of services. It is not just providers who will assess the quality of care:

"We will also encourage more widespread use of patient experience surveys and real-time feedback. We will enable patients to rate services and clinical departments according to the quality of care they received ... " (Department of Health (2010) *Equity and Excellence*, page 14)

Although this policy had not been turned into practical proposals by the time of fieldwork in the present study in 2011, it appeared to represent a further shift in thinking, a shift from service provider to service user, about how feedback would be used to assess the quality of services. Instead of patients providing information in the form of feedback and the provider making the assessment of quality, patients would themselves make the assessment of quality. This change, if translated into practice, might reduce the requirement that providers of service identify explicit criteria or standards by which improvements resulting from feedback would be judged. Service

standards and improvements, building on the notion that patient experience relates primarily to the subjective perceptions of patients of the interpersonal aspects of care, would then be assessed only in terms of patients' own assessments of quality and patient satisfaction.

If the focus in the use of patient feedback is on patient experience and what patients want, questions about the criteria and standards of improvement resulting from feedback focus not on criteria of improvement in services per se but on the criteria of improvement for patients. In the simplest forms, the use of feedback is judged in terms of 'does feedback help patients get what they want?', 'does feedback help increase patient satisfaction?' and 'does feedback improve patient experience?' In this analysis the emphasis is not on improvements for patients or improvements for the benefit of patients, it is on improvements in patient experience as judged by patients. In the words of one service manager:

"Well it doesn't matter what I think, it doesn't matter what anybody who works in this place thinks, what matters is what the service users think. And that's the key really. So our outcome, our hard outcome has got to be what the patients think, no matter how fantastic we think the service is, if the patients think it's rubbish, it's rubbish." (Allied Health Professional NE, Hillside Hospital)

Here NE explicitly rejects the idea that providers' assessments of the quality of service have any ultimate validity. It is the patients' assessments of quality, based on their own experience, that are important. The potential implication of this view is that patient satisfaction with services is the true measure of quality and that increases in satisfaction are the reason for collecting and using patient feedback.

4.3 Improving Hospital Services

I have argued in the previous section that one of the main uses of patient feedback, as identified in government policy and by managers at Hillside and Northbank Hospitals, is to improve patients' subjective experience of services. But this is not the only aim in collecting and using feedback from patients. This section examines the ways in which feedback is used to improve, not patients' experience of services, but the quality of care and the quality of services as defined by policy-makers and service providers. Government policy and managers in hospitals sometimes talk about using feedback to improve services without mentioning 'patient experience' at all.

In this section I draw on formal legislation and Department of Health policy guidance and on interviews with managers at Hillside and Northbank Hospitals. Legislation, in the form of statutory instruments, imposes legal obligations on NHS foundation trusts as on other organisations. Legislation provides relatively precise statements about what trusts must or must not do, but in itself provides no background explanation or justification of particular policies. Department of Health policy and guidance identifies more clearly, but still in formal terms, the aims of collecting and using feedback to improve services. Interviews with managers, while being consistent with these broad aims, often set the aims of using feedback in a much more complex context and present them with more variability and with different shades of meaning. It is the data from interviews with managers that in this section provide the most immediate and detailed understanding of how feedback from patients is used to improve services for patients.

Although much of the focus DH guidance in the late 2000s was on 'patient-centred care', dignity and respect, policy makers were at the same time, especially in the wake of the Mid Staffordshire Hospitals scandal, developing the view that patient feedback should be used to help ensure the safety of services. The Health and Social Care Act (2008) created the Care Quality Commission, gave it duties relating to the quality and inspection of health and social services, and required providers of health or social care to register with the Commission. Subsequent policy focused not only on the use of feedback to improve services but also on reducing the risk of harm to patients. Section 10 of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 stated that a person registered to provide health or social care services must protect service users against the risks of inappropriate or unsafe care and treatment, and for this purpose must, among other things, have regard to the complaints, comments and views of service users. The registered person must seek the views of service users in order to come to an informed view about the standard of care and treatment provided. Similarly Section 19 stated that, in order to assess, prevent or reduce the risks of unsafe or inappropriate care or treatment, the registered person must have in place an effective complaints system for receiving, handling and responding appropriately to complaints and comments made by service users. Although the Regulations do not at this point specify the actual standards of safety, care and treatment that should be met, they do state that providers of services should seek the views of service users to come to an informed view about these standards. The Regulations thus point towards the ways in which providers of health services are

expected to use patient feedback to help set standards to improve the safety, and potentially the quality, of services.

Despite the emphasis in recent government policy on the safety of patients and despite the high priority given to safety in the plans and quality improvement initiatives at Hillside and Northbank Hospitals only one manager in interview identified patient safety as the aim of collecting and using patient feedback.

“And you know it’s those kinds of measures that then stop absolute disasters like at Mid-Staffs. You know, I can put my hand on my heart and say that couldn’t happen here because there’s too many ways that we would find out. You know and we’d find out quickly. So you know, touch wood, I feel quite confident in those kind of things that we can actually see instantly over the course of a couple of weeks if suddenly a ward’s deteriorated for some reason. And we can look at why that is and work with the staff.” (Corporate Manager IE, Hillside Hospital)

Despite IE’s shift in emphasis (from ‘hand on my heart and say that couldn’t happen here’ to ‘touch wood, I feel quite confident’) her point is clear. The regular, detailed collection at Hillside Hospital of patient feedback through the How Are We Doing? survey, combined with the analysis and reporting of the data at ward, divisional and Trust-wide levels would mean that deterioration or problems in the safety of services would be quickly identified. Managers could then take action to prevent any further deterioration and improve services.

Complaints procedures in the NHS are established under the Health and Social Care (Community Health and Standards) Act 2003 and subsequent regulations. The Act itself and The National Health Service (Complaints) Regulations 2004 focused exclusively on complaints procedures and the role of the Commission for Health Audit and Inspection. The Local Authority Social Services and National Health Service Complaints (England) Regulations 2009 then aligned NHS and adult social care complaints procedures into a single set of arrangements. While the 2009 Regulations maintained the legislative focus on the procedural elements of the handling of complaints, the policy was developed with a new aim of using complaints as feedback to help improve services:

“In many cases, people are supported to make their complaints heard, and responsive and responsible health and care service organisations hear and respond to those views and learn from their mistakes, improving their services continually. But those

organisations tell us that this is sometimes despite the current complaints arrangements.” (Department of Health (2007b) *Making Experiences Count*, page 15)

In this policy, complaints reveal mistakes; organisations should learn from their mistakes; the purpose of learning from mistakes is to improve services; improving services is the objective.

The idea of service improvement was further developed in the guidance issued after the 2009 Complaints Regulations had been issued. The focus on learning from complaints to improve services was developed in further detail in the subsequent Department of Health (2009a) guidance ‘Listening, Responding, Improving. A Guide to Better Customer Care.’ Although much of the guidance was concerned with the handling of complaints, with listening to the complainant and responding to the way in which the complainant wanted the complaint to be handled, the guidance also provided for the first time in DH policy some detail about how organisations should use feedback in the form of complaints to improve services. Improvement was set partly in the context of ‘Improving customer focus’ and ‘What makes a happy customer?’. The guidance told service managers:

“You can use any comments, compliments, concerns and complaints you receive to: tell you what’s working; help you identify potential service problems; help you identify risks and prevent them from getting worse; highlight opportunities for staff improvement; provide the information you need to review your services and procedures effectively.” (Department of Health (2009a) *Listening, Responding, Improving*, page 36)

One of the innovations in policy here is a shift in emphasis from seeing complaints in isolation to setting them alongside comments, compliments and concerns as different kinds of feedback that can be used to improve services. Another shift is the change, from seeing due process in the handling and response to complaints as the only policy objective to seeing in the words of the title of the guidance listening and understanding patients’ concerns and improving services as an equally important objective. The guidance provides the beginnings of an analysis of the different ways in which this feedback can be used to improve services. Feedback can be used to identify what’s working well and to identify problems and risks, to prevent problems getting worse, to contribute to staff training and improvement, and to support the review of policies and procedures. This guidance is substantially wider in scope than the changes in the Regulations themselves; it is more detailed than any of the earlier policy or guidance

in suggesting specific uses of feedback. The language of the guidance (talking about 'problems', 'improvement' and services 'working well') suggests, but does not explicitly state, that improvement in services can be objectively assessed by providers of services or other external agents using explicit criteria and standards of quality. But, despite this suggestion and despite the detail about the uses of feedback, the guidance contains no further systematic analysis of the nature of improvement or the criteria and standards by which changes resulting from the use of feedback should be judged.

The primary aim of collecting and using patient feedback is, for many managers, to improve services. This aim is often identified in very general terms. It is about improvement or making things better.

"Well I can't speak for everyone, but I can speak for myself. I don't think there's any point in collecting feedback unless you're going to turn that into action that is going to improve things." (Project Manager AR, Northbank Hospitals)

And, in slightly more detail:

"And there are other areas where it's just is, 'Look we could actually do things a bit better,' you know, perhaps change, you know, 'we've been doing this for years, why don't we try something else?' So a bit of, you know, improving the service, the way we deliver it." (Directorate Manager IM, Northbank Hospitals).

At this basic level managers say that the aim of using feedback is to improve services. These general statements do not identify the domains of feedback that will be used or the aspects of services that are to be improved. Nor do they suggest any of the criteria for improvement or standards of service by which the use of feedback would be judged. But, despite these limitations, service improvement is for these managers the basic purpose for collecting and using feedback from patients. In this they differ from those managers who say that the basic aim of collecting and using patient feedback is to improve patients' experience. Concepts of service improvement were not clearly defined by these managers in interview but did relate to a number of more specific ideas, to do with quality, treatment and care, and the safety of services.

Improving the quality of care is for many managers central to the idea of using patient feedback to improve services. 'Care' appears to differ from 'treatment'; it is to do with the way individual patients are treated and looked after; but it is also a narrower concept than 'service'. The aim of using patient feedback is for these managers to improve the quality of care.

“It has to be that you want to give the best care you can and you want to enable your staff to do that. So to identify when you don’t and why you don’t is a critical part of that loop. And as painful as it can be, it’s a very important part.” (Clinical Director EE, Northbank Hospitals)

By talking about the quality of care, as distinct from the quality of services more generally, managers may be focusing to some extent on the clinical work of doctors and nurses and on the interactions between service staff and patients. But for many managers improving quality is not only about improving the quality of care for individual patients; it is about broader issues of service provision and delivery.

The aim of using patient feedback is seen by some managers as being to improve the quality of services more generally. The use of feedback is set in the context of the broader objectives and pressures in the NHS.

“You’ve only got to look at the agenda coming out of the NHS at the moment and it’s around quality, and it’s around ensuring that you can demonstrate quality. It’s shifted slightly away from efficiency – financial efficiency, operational efficiency, to some extent, but with a greater focus now or an equal focus on quality.” (Corporate Manager HMcN, Hillside Hospital)

Although the concept of quality, either as it relates to the quality of care or the quality of services, is not clearly articulated in these replies, it is to some extent differentiated from other attributes of services. ‘Quality’ is distinguished from for example equity, efficiency, productivity or outcomes. But the introduction of the concept of quality does not in itself identify specific criteria and standards by which improvements from the use of feedback can be assessed.

The development of ‘patient-centred services’, a phrase that itself appears in the Institute of Medicine definition of quality, is seen by managers as one of the main components of quality to which the use of patient feedback may contribute. Managers identify the aim of using feedback as being to make services more responsive to patients or more ‘patient-centred’.

“I think they are genuinely trying to engage with patients in a collective approach to making services better and being responsive to patients.” (Divisional Manager AN, Hillside Hospital)

‘Patient-centred care’ is for some managers the main aspect of the quality of services that they identify.

“Actually for some groups of staff it’s really important that we are collecting this data and acting on it, because we do want to be seen to be a hospital that does provide good care. And that creates a sense of pride which helps that service quality change, in ensuring that people continue to be very motivated to provide that patient-centred care.” (Project Manager LT, Hillside Hospital)

For other managers, patient-centred care is one among a number of different aspects of quality that underpins the use of patient feedback.

“We’re trying to really understand what patients want. ... But without patient input, we’re never going to get it right, and if we want to be truly patient centred, and tailor care, then we can’t do it without patients.” (Consultant Nurse VN, Northbank Hospital)

For VN, patient-centred care is linked to the idea of what patients want and tailoring care to what patients want. Feedback is collected to learn about what patients want and is used to make services more patient-centred. For others, such as AN and LT, the emphasis is not so much on what patients want as on making services responsive to patients or centred on patients. This view is similar to the focus of the Darzi Report and other NHS policy on compassion, dignity and respect. Using feedback to help make services more responsive to patients and more patient-centred is for these managers the same as using feedback to improve the quality of services.

Using feedback to improve the quality of services may not be the same as using it to improve the quality of treatment and care. In discussing improvement in services and quality as the aim of using patient feedback, managers draw distinctions between clinical treatment and care and other aspects of service provision. The primary aim of collecting and using feedback was for managers not to improve the accuracy of diagnosis or the appropriateness or effectiveness of treatment.

“Our concern is always ‘Have we got things right clinically?’ And I think probably patient feedback doesn’t contribute much to that, because people who have had excellent clinical care may be the ones who are most likely to complain.” (Consultant Physician FM, Hillside Hospital)

Here FM is commenting not on the logical relationship between feedback and clinical treatment but on empirical observation that feedback in the form of complaints contrasts with the ‘excellent clinical care’ that patients have received; feedback is therefore in her mind about something other than clinical care. Other managers

similarly in interview drew an unclear distinction between the use of feedback to improve the quality of clinical care and its use to improve administrative processes.

“So a lot of these issues are, potentially easily resolvable if you get in there early enough, and I think there is that sense of most of that could have been resolved easier and that it’s generally not about quality – I mean sometimes it is about quality of care, but generally about the administrative processes that sit around the clinical care.”

(Corporate Director RI, Northbank Hospitals)

Patient feedback is, in this analysis, collected and used not so much directly to improve to improve the quality of technical treatment and clinical care provided by doctors, nurses and other health care professions as the quality of interaction and communication through which treatment and care are provided and the organisational context in which they are provided.

Executive Director WB at Northbank Hospitals provided in interview a rationale for this approach. He spoke in public at a meeting of the Board of Directors, during a discussion about telephones and the ability of out-patients to contact the Trust, about patients and customers; he said in the meeting that it was important to see patients as customers. He was asked subsequently in interview what he had meant by the difference between patients and customers.

“Personally I think it’s quite important, because I’m – what I distinguish is – how can a patient – all of our customers are patients and all of our patients are customers, so that’s – you know at one you know at one point I think you know the words are interchangeable. Why I think it’s important to distinguish them, I think when you’re talking about ‘a patient’ it seems to me that in the best sense of the word paternalism is justified, because you’re talking about someone who on the whole cannot be expected to know what is good or bad or indifferent, because it’s to do with professional standards.” (Executive Director WB, Northbank Hospitals)

WB then illustrated the distinction he was making by saying that patients could not be expected to know which was the appropriate valve to be used during a heart operation but that they did know and had every right to be consulted about what time they should wake up in the morning. The immediate point here is the distinction that WB is drawing between professional knowledge and lay people’s experience, a distinction that is very similar to Consultant Physician FM’s view that ‘clinical care’ is the

responsibility of clinicians and is not the subject of patient feedback. The broader point is that for a variety of reasons, the emphasis of managers and clinicians is on the use of patient feedback not to improve patients' subjective experience of services but to improve the quality of services as identified and defined by managers themselves.

4.4 Patient Feedback, Patient Experience and Service Improvement

In the previous two sections I have presented contrasting views of the use of patient feedback: to improve the subjective experience of patients; and to improve the quality and delivery of services. This analysis leads to two different views of the purpose of collecting and using patient feedback: patient feedback about patients' experience of services could be used to improve the quality of services; or patient feedback could be used to improve the quality of services so that patients have a better experience and are more satisfied with the service. In this section I examine the relationship between these two uses of feedback; I examine the question whether managers use feedback about patients' subjective experience of services in order to improve the quality and delivery of services as they themselves define quality or to improve patients' subjective experience as an end in itself.

In this section I draw primarily on data from interviews with managers at Hillside and Northbank Hospitals. Interviewees talked quite informally, and often in quite personal terms, about the reasons for using feedback from patients. I also draw in this section on data from interviews, Trust documents and informal observation of a new chemotherapy day unit at Northbank Hospitals, which was drawn to my attention by interviewees as a good example of the use of patient feedback. My analysis of this example illustrates how feedback about patients' experience can be translated into plans for the design of wards and departments and the delivery of services.

Some managers in interview talked, as I have shown in Section 4.2, about the use of patient feedback to improve the subjective aspects of patient experience. Others talked in a different way about patient experience. They focused not so much on the subjective aspects of experience as on the objects or domains of experience, the treatment, care and services that patients were experiencing. And some talked about patient experience in ways that combined or did not distinguish between different meanings.

“Really, I suppose it’s focused on the patient experience, really, and trying to make that better. And if you include food as part of that, that’s probably very important isn’t it? It can also flag up issues that can improve efficiency if you like, discharge, confusion on discharge actually costs the Trust a ton of money, by lengthening the length of stay unnecessarily. But really it’s to make their stay a bit more pleasant and efficient and you know go home better and feeling good really.” (Governor AD, Hillside Hospital)

Here AD says that the reason for collecting patient feedback is making ‘patient experience’ better. Patient experience is presented in terms of service organisation and delivery – food and the organisation of discharge from hospital. It is also presented in terms of patients’ subjective experience: patients’ stay in hospital is pleasant; they go home ‘feeling good.’ In combining all of these reasons for using feedback, Governor AD (as with some other interviewees) did not distinguish between the different dimensions of patient experience and patient feedback on which I am focusing here.

Although the aim of collecting and using patient feedback is seen by some managers as focusing almost exclusively on patient experience and patient satisfaction, as distinct from the aim of improving services and the quality of care, the aim is for others a complex mix of patient experience and service improvement. They combine the general idea of improving services with more specific statements about improving the quality of care or improving patient experience.

“Well basically because we’re running a service, we want to give the best service, we want to improve what we’re doing because you don’t want patients leaving, feeling dissatisfied. You know, you don’t want patients coming in to hospital without an infection and leaving with an infection. You don’t want that sort of thing. So the main aim of doing this is to make sure that we can improve the care that we give to our patients. I want everybody on my ward to be happy, you know.” (Ward Manager BM, Hillside Hospital)

BM here links three reasons for using patient feedback: to improve the service and to provide the best service she can; to patients to be satisfied or happy; and for patients not to get an infection while in hospital. The aims of using feedback are for BM equally to improve the quality of services and for patients to be happy, to improve patient experience. Similarly for other managers, the patient experience and the quality of services sit alongside each other.

“I think it’s ensuring that you’ll be making changes, the changes that people want and really about driving up quality for them.” (Project Manager LB, Northbank Hospitals)

And again.

“ ... for me it’s around thinking about how can, you know, how can we make this patient’s episode of care, wherever it might be, the best that it possibly can be? And that they have a good experience and that they get through it, because whether it be cancer or a long term condition, that is a traumatic experience for that patient. So how can you make it as easy as you possibly can for the person? And how do you, I think it’s also around individualising care ... “ (Directorate Nurse Manager SO, Northbank Hospitals)

For SO, the aim of using feedback is to individualise care and provide ‘the best’ quality of care; it is to provide ‘a good experience’ and to make it as easy as possible for the patient. The aim of using patient feedback, for both these managers is to improve patient experience and also to improve the quality of services.

The focus is for many managers in various ways on using feedback about patients’ experience of services in order to improve the quality of services. In this context, patient experience (and hence patient feedback) is not an end in itself but is a means to the end of improving services. The aim of using patient feedback about patients’ experience of services is to improve the quality of the services.

“Well I see it as a way to know how we are doing, you know, that’s the title of our survey. We think we’re doing the best, that’s what everybody comes to work for. We think that we’re treating people, caring for them in the most efficient and responsible way we can, and if we hear from patients that we’re not, then we need to know that. That’s fundamentally what it means to me.” (Divisional Manager GC, Hillside Hospital)

In these replies part of the focus is on the service – the quality of service, delivering care in an efficient and responsible way. But the focus is not on care and the service in isolation. It is on driving up quality of services for patients, caring for people efficiently and responsibly. The criteria for and standards of improvement from the use of feedback relate not to service standards in isolation or to patient experience on its own, but to standards of service provided for patients as judged by the experience of patients.

A substantial practical example of the use of feedback about patients' experience of services to improve the quality and delivery of those services related to the design and development of a new chemotherapy day unit for cancer patients at Northbank Hospitals. Feedback was collected and used as part of the patient involvement strategy of the Trust. Feedback about patient experience was an integral part of the design process for the chemotherapy day unit. The accommodation and organisational arrangements for the new unit were designed so that patients would have a better experience of service than they had had on the old unit.

"So that's why we decided to go forward now with the chemo unit in *Wastell* tower, which – and that was developed and designed with patients. And that was completely, I mean they were very much – and interestingly it was designed very differently because patients were involved. You know, we changed – had to change that plan completely on the back of what patients wanted, the absolute opposite of what we assumed they would want. ... Yes, it's a great example of how, you know however altruistic and patient-focused you actually are, you don't actually know what patients want until you ask the patients themselves." (Executive Director WB, Northbank Hospitals)

The project used an experience-based design methodology, in which patients were initially interviewed individually about their experience of services; recordings of the interviews were analysed to identify key 'pinch points' or significant issues seen from the patient's point of view in the pathway of care. Focus groups of patients were then brought together in facilitated discussions to identify and talk about potential solutions to the problems and help identify priorities. Trust managers identified a programme of work and the resources needed to take it forward through a formal project management structure with continuing monitoring, advice and support from a patient working group.

The chemotherapy day unit project at Northbank Hospitals began in 2008 with the collection of patients' views about the existing service; accommodation was identified in an existing hospital building and converted for its new use, and the new unit opened early in 2011. In the early interviews and discussions with staff and managers patients identified problems with the environment and layout of the treatment, reception and waiting areas, with issues of sociability and privacy, with the general atmosphere of the unit and the way this impacted on relationships between staff and patients. Patients' feedback and preferences influenced in the new unit the

design and layout of reception and patient waiting areas, including the provision of internet access for patients, in ways that impacted on visibility and communication and the relationships between patients and staff. They influenced the decoration and artwork in circulation and waiting areas. They influenced arrangements for team working among staff so that patients, instead of being allocated each session to an individual nurse who might be different person for each treatment session, were allocated on a tumour-site specific basis to a team of nurses who as a team provided continuity of care between sessions. And they influenced the layout and design of consultation and treatment areas, so that patients had privacy and equality of status with clinicians in individual consultation areas but shared four-chair treatment areas with a degree of contact and communication with other patients with tumours of the same site during treatment sessions. In including these features in the design of the new accommodation and service, managers were responding to what patients wanted and valued; feedback about patient experience was a major influence, if not on clinical treatment, on the design of accommodation and the delivery of the service for patients.

The example of the chemotherapy unit, as with the comments of managers quoted earlier in this section, shows a complex relationship between patient feedback, patient experience and the improvement of hospital services. Feedback is collected from patients, through surveys and as part of patient involvement initiatives. The feedback is about patients' experience of services and about the quality of care and the quality of services. Although feedback is used both to improve patient experience and to improve the quality of care, the focus for many managers is not primarily on using feedback to improve patients' experience of and satisfaction with services; it is on using feedback about patients' experience in order to improve the quality of services in accordance with criteria and standards that themselves define.

4.5 The Use of Feedback: Criteria and Standards of Improvement

I have shown in the previous sections of this chapter that, although patient feedback is used in a complex mix of ways to improve patient experience and to improve the quality of care, the focus is often on using feedback about patients' experience in order to improve the quality of services as defined by managers rather than on improving quality in order to improve patient experience or satisfaction. In this section I examine how far this analysis is also true of the formal reporting systems used by Trusts. I examine data from Trusts' Quality Accounts for 2010/11 and reports

about patient feedback presented to Trusts' Boards of Directors in 2011; does the benchmarking and reporting of the results of patient feedback directly reflect patients' subjective experience or specific aspects of the provision of services; or are they instead arithmetical and presentational artefacts that themselves form the basis for the judgements about quality?

In this section I draw primarily on data from formal documents and Board reports at Northbank and Hillside Hospitals and reports of national surveys of patients by the Picker Institute, supplemented by some interview data. The Trusts' Quality Accounts provide overviews of the Trusts' achievements in the previous year and priorities in the coming year for quality improvement; they provide commentary on and information about the standards that Trusts have achieved and the targets that they plan to achieve. The Trusts' Performance and Patient Experience Reports contain very little commentary about the aims and objectives of using patient feedback; they do contain very detailed numerical information about performance against explicit targets or standards set by external agencies or by the Trusts themselves. This numerical information and the way it is presented can themselves be analysed to identify and explicate the criteria and standards of quality and the use of patient feedback that are embedded in each Trust's management systems.

The annual Quality Accounts that all NHS trusts are required to prepare provide a formal view of the use of patient feedback about the quality of services provided by the trust. Quality Accounts for 2010/11 provide information about achievements in 2010/11 and plans for 2011/12. The Northbank Hospitals' Quality Accounts for 2010/11 were presented in a way that identified for each of the quality priorities the aim of and rationale for the priority and the criteria for success. The Accounts thus provide a framework in which the use of patient feedback could be assessed in terms of the substantive issues to which the feedback relates and the criteria and standards used to judge improvement. The Accounts set the use of patient feedback more firmly in the context of patient experience and the quality of services than in the context of patient involvement. The achievements and performance of the Trust were frequently expressed in terms of improving patient experience. Within this broad framework the Quality Accounts identified two broad approaches to improvement, focusing on national (and local) patient surveys and CQUIN targets, and on individual service and quality improvement initiatives.

The Northbank Quality Accounts set out the Trust's priorities for 2011/12. The priorities were presented in terms of patient safety, clinical effectiveness and patient experience, patient experience being:

“... meeting our patients’ emotional as well as physical needs. This includes being treated with dignity and respect in a comfortable and safe environment, and being given the appropriate information about their care.” (Northbank Hospitals *Quality Accounts 2010-11*, page 2)

The patient experience priorities were identified in terms of ‘improvement’: improving end of life care; a renewed focus on dementia care; improve patient experience responses to the national survey; improve women’s satisfaction with maternity care; and improve patient information leaflets. The Quality Accounts then identified the Trust’s reasons for choosing these priorities and the measures of success for each of them. The Trust’s public stakeholders had ranked end of life care, dementia care and patient survey improvements as the three highest priorities for the year. The Department of Health had chosen five national patient survey questions as key areas for all NHS Trusts in England to focus on. Maternity services were included because:

“Our maternity survey results came out after the public engagement on our priorities for 2011/12. However, our results show that we need to improve satisfaction with our maternity service.”

(Northbank Hospitals *Quality Accounts 2010-11*, page 5)

Patient feedback in the form of survey results thus formed the basis for two of the five patient experience priorities for the year. The criteria for success in these two priorities (the national patient survey scores and maternity services), but not for the Trust’s other priorities, were then based on improving patient satisfaction scores by a specified number of percentage points in line with the Trust’s CQUIN targets for 2011/12. Quality improvement, as presented in these Accounts, is assessed not in terms of systematic analysis of patients’ emotional needs, subjective experience or satisfaction, but in terms of specific service changes or patients’ answers to specific questions about how services are provided.

The monthly Performance Reports presented to the Board of Directors at Northbank Hospitals reflected a focus on patient feedback and patient experience not as an end in itself but as information contributing to the achievement of the Trust’s operational targets and contractual obligations. The emphasis in the Performance Reports differed in this respect from the Quality Accounts. The Performance Report and Chief Executive’s Scorecard at Northbank Hospital contain four main sections: indicators used for external assessment (Monitor and the Care Quality Commission); indicators related to CQUIN programmes; indicators of high quality, efficient services; and information assurance assessment. The Report also contains graphs showing

efficiency and productivity measures and detailed data showing performance against Department of Health 18 week referral to treatment time targets. The relatively priority given in the reporting systems at Northbank to performance targets was made clear in interview:

“So I would say the hardnosed performance targets are very much to the fore part of our routine reporting. And we have a structured system of reporting those to the management executive and to the Trust Board on a regular, you know, on a monthly basis, against those.” (Corporate Director RI, Northbank Hospitals)

The only information about patient feedback included in the performance reports at Northbank Hospital in 2011 related to national patient survey data and the development of local surveys as part of the Trust’s mandatory CQUIN targets within contracts with commissioners. Other information about patient feedback was not included in the reports. Despite the focus in the Quality Account on patients’ emotional needs, performance reports at Northbank Hospitals did not include information about patients’ subjective experience of services.

The Hillside Hospital Quality Account 2010/11 was less explicit than the Northbank Account about patients’ emotional needs and subjective experience, but it did include a wider range and more detail of information about the results of surveys of patients and consistently used the term ‘patient experience’ to refer to these survey results. It reported on the Trust’s performance 2010/11 in improving patient experience by using their How Are We Doing? survey results. The Account identified specific objectives within the broad priority and drew on the How Are We Doing? survey and other kinds of patient feedback to give measures of improvement. The first objective was to use the Trust’s ‘First Choice’ Transformation Programme to improve patient experience in creating a culture of care, expanding the volunteer programme, improving patient food service and nutrition, and improving patient experience of discharge. The Account provided little information about the results of these initiatives but did include quotes from two patients illustrating difficulties and improvements in food service. The second objective was to achieve target patient satisfaction scores for CQUIN metrics in three poor performing wards and across the Trust as a whole. These were measured by the results of the local How Are We Doing? survey and the national in-patient survey; the Trust achieved all the targets for this objective. The third objective was to achieve the Trust’s own How Are We Doing? survey target or benchmark. The target was set in terms of a percentage score for all patients in the survey, based on a benchmark set at the level of scores

in the national in-patient survey of the highest performing trusts in the local area. The Account reported that overall the Trust did not achieve the target and that the score remained at the same level as the previous year. There had been improvements in specific areas, as measured in the local survey and in the national in-patient survey. In reporting the results of quality improvement initiatives, as in establishing new initiatives, the Trust uses the words 'patient experience' and then sets all its objectives and measures of outcome in terms of the results of the local How Are We Doing? survey of patients. The terms of the survey questions and analysis of the results thus become crucial to the understanding of the criteria and standards of quality improvement initiatives in the Trust.

The results of the How Are We Doing? survey are included every month in the Performance Report and the more detailed Patient Experience Report that are presented to the meeting of the Board of Directors at Hillside Hospital and contain detailed information about criteria and standards of service quality and improvement. The survey itself is based on 28 questions drawn directly from the much larger national survey of in-patients. The answers to the questions are presented in three groups: patient engagement (e.g. 'When you had important questions did you get answers you could understand from doctors?'); environment (e.g. 'In your opinion how clean was the hospital room or ward that you were in?'); and care perceptions (e.g. 'Do you think hospital staff did everything they could to control your pain?'). The criteria and standards are not spelled out in written text of the reports at Hillside Hospital but are embedded in the scoring and reporting of the results. The scores for each domain of feedback are based on the number of patients giving particular replies to the survey questions. Changes month on month in the scores show whether the quality of service in that domain is improving or deteriorating, a higher score is an improvement, a lower score a deterioration. The scores for each question are compared with benchmarks established by reference to scores of the top 20 percent of Trusts in the national survey of hospital in-patients. An HRWD score at or above the benchmark is colour coded green; a score below the benchmark is colour coded red. Success or failure to achieve the desired standards is thus clearly visible at any one point in time.

This analysis shows that the ways in which the results of patient feedback are used in the monitoring and management of services at Northbank and at Hillside Hospitals have much that is in common with each other, but also that there are some significant differences. The things that are in common are that regular reports to the Boards of Directors, scorecards and performance management reports used in the

hospitals are based on quantified survey results rather than other kinds of feedback. The results of surveys are used to assess and measure the quality of services against criteria and standards that are themselves based on the surveys. The changes in performance and the achievement of standards thus relate to the survey questions, themselves asking for patients' views about specific aspects of the treatment and care they have received and the services they have used. These questions are framed not in terms of patients' subjective feelings or satisfaction but about their views of the care they have received and the services they have used. Improvement in both Trusts is measured in terms of the results of surveys.

At the same time there are differences between the Trusts in how they assess services and measure improvement. At Northbank Hospitals targets are set and improvement measured by reference to externally set or contractually agreed standards in national surveys of patients. Regulatory requirements and CQUIN targets determine the priority that the Trust gives to the use of patient feedback. At Hillside Hospital, although the performance reports and management scorecards give priority to regulatory requirements and CQUIN targets, they also include benchmarks and targets based by the Trust itself on its own local How Are We Doing? patient survey. In Chapter 6 I will examine how the Boards of Directors in the two Trusts themselves used these different kinds of feedback. In the next section I examine how the results of feedback through national and local surveys of patients were used in two service improvement initiatives in the Trusts: cancer services at Northbank Hospitals; food and feeding at Hillside.

4.6 Using Feedback to Improve Services: Two Examples

I have shown in the previous sections of this chapter that, although Trust managers sometimes talk about the aim of using patient feedback as to being to improve patients' subjective experience, they more frequently use feedback about patient experience to improve the quality of services in ways they themselves identify and measure. Moreover the measurement and reporting systems that Trusts use to identify and communicate the results of patient feedback themselves are themselves used to create the criteria and standards of improvement and themselves become the focus of managers' attention. My purpose in this section is to examine these arguments in the context of two practical examples of the use of patient feedback – the use at Northbank Hospitals of the results of the 2010 national survey of cancer patients, and an initiative to improve food and feeding at Hillside Hospital.

4.6.1 Cancer Services at Northbank Hospitals: The 2010 National Cancer Patient Survey

The previous sections of this chapter have shown that patient feedback is used to promote specific improvements in the quality of services. I have argued that national and local surveys of patient are a major source of the feedback used by Trusts, but I have not yet presented detailed evidence about how surveys are actually used to help improve services. The purpose of this section is to examine how the results of the 2010 national cancer patient survey at Northbank Hospital were used to support the development of services in 2011. The analysis shows that that, although feedback in the form of survey results is used to help improve services, there is not a direct relationship between the results and the use of feedback or between the use of feedback and the stated overall aims of the service.

In this section I draw primarily on data from interviews with managers at Northbank Hospitals and on the results of the 2010 national cancer patient survey itself. The results of the survey are presented here simply as factual background information; the interview data explores how and why managers in the Trust did or did not make use of them in particular ways. I additionally draw on my observation of the meetings of the Board of Directors at Northbank Hospitals, focusing especially on one meeting that included a presentation by senior clinicians and managers in the Trust's cancer services about the strategy for the service. My observation of this meeting in particular helped me understand the context in which the Trust considered and made use of the 2010 survey results.

The results of the national cancer patient survey were published in December 2010 in the form of national summaries and detailed results for each of the 158 NHS trusts that participated. The 2010 survey was the first survey of cancer patients since 2004; it was larger than the 2004 survey and included all kinds of cancer patients for the first time. Patients discharged between January and March 2010 were included in the survey. More than 1,000 patients of Northbank Hospitals (with cancers of the breast, lung, prostate, bowel, bladder, reproductive organs or other sites) participated in the survey. The Director of the Cancer Programme was given responsibility for analysis of the results and presented the results to the Trust Management Executive. Cancer Programme managers co-ordinated action planning across the various directorates in the Trust that provided services for patients with cancer. Formal responsibility for planning and taking action in response to the survey lay with the

clinical directors and the clinical leads and service management teams in each directorate.

There were varied responses in Northbank Hospitals to the results of the survey. The results of the survey were considered and discussed by the Trust Management Executive, but were not presented to the Board of Directors in public meetings. In May 2011 the Director of the Cancer Programme, the Director of the Integrated Cancer Centre and the Clinical Director of Clinical Oncology made a presentation to the Board about cancer services, which focused exclusively on improvements in clinical treatment and care, plans to build a new £160 million cancer treatment centre, and the development of integrated cancer services on a sub-regional basis. In discussion directors raised issues about the difficulties in achieving referral to treatment times in specific services and noted the improvements that had been achieved in urology and other services, but did not mention 'patient experience' or the national survey. There was no discussion at the Board of the results of the recent survey as part of the strategy for the cancer service development.

Managers in interview drew attention to the opportunities and difficulties in interpreting the survey and taking action on the basis of the results. Consultant Physician ET talked in interview about the development of specialised clinical treatments and about the Trust's planned new integrated cancer centre. When asked what people were trying to achieve in collecting and using patient feedback in oncology services he replied:

"A world class cancer service. We want to be known across the world as having one of the best services for cancer patients, of all tumour types, at any stage of their treatment. ... (*Patient feedback is*) key because we cannot be sure that we've achieved that without being told by patients that they are completely satisfied with their care." (Consultant Physician ET, Northbank Hospitals)

But, at the same time there were difficulties in interpreting and making use of the results of the survey. Corporate Director EO described the analysis and interpretation of the Trust's results as they related to different organisations and services as a 'headache'. Consultant Surgeon WJ, recently appointed to the Trust after working for 20 years as a consultant in another city, talked in interview about discussions in the Trust about the results of the survey:

"I thought we could have – my point about the data that I mentioned to you before was that there was a massive amount of data, and all that this Trust were interested in was how we did in relation to (*other*

hospitals locally), when I felt we should really have been heading for the Christie, Marsden, specialist centres. ... And I wanted us to compare ourselves, and you know so if Leicester were doing good I wanted us to be at that level. And I was disappointed that that really wasn't taken into consideration." (Consultant Surgeon WJ, Northbank Hospitals)

WJ is making the point here that the Trust's senior managers, 'the Trust', do not in practice accept the validity of ET's argument that patient experience is an essential element of a high quality service and that the Trust should be aiming to provide world-class services. They were more interested in local comparisons and benchmarks. The implication of his view is that the use made of feedback from patients depends not on the feedback itself but on the importance and priority that managers locally attach to it.

Although some senior clinical staff and managers found the results of the national cancer survey disappointing, managers did not in interview highlight some of the main findings. My analysis of the survey results showed that the Trust was in the bottom 20% of trusts in England in 28 questions, almost half of the 59 questions that patients were asked in the survey. But this was not mentioned by managers in interview; instead managers tended to point to the boundaries of confidence in the data:

"... you get big red crosses at the ones that were in the bottom 20%. It's quite interesting when you look at statistical significance, because bottom – because some of the ranges who are quite small, so the bottom 20% could still be like 90% of people ... " (Project Manager AR, Northbank Hospitals)

Discussion about the statistical validity and interpretation of the results sometimes, but not always, took up more time than discussing problems and planning action. The Trust's clinicians and managers involved with cancer services focused in interview on some of the disappointing results – especially difficulty in contacting clinical nurse specialists – of the survey; they did not talk about the overall performance of the Trust, perhaps because they did not want to expose the Trust in the context of the research or because they tended to discount the validity and value of the results.

Despite the caution and reservations, data from interviews and the Trust documents show that a variety of actions were taken in the Trust to improve services as a result of the survey. These include for example: work with doctors to improve communication with patients and giving of diagnoses; reviewing procedures and

communication with patients in preparation for surgical operations and discussion postoperatively; moving oncology clinics from one hospital to another; improvements in communication and accessibility of clinical nurse specialists; developing, as part of the national survivorship programme, new kinds of advice and support at the end of treatment for patients who do not need to be followed-up any longer in out-patient clinics.

Contacting clinical nurse specialists (CNSs) was given in several interviews as an example of a significant improvement resulting from the survey. The Trust was well-staffed with CNSs; the survey showed that patients knew the names of their CNS but found it difficult to contact them. In the words of Consultant Nurse VN:

“As head of the nursing team, I suppose the basic nursing team scored very low in being contactable for the patients. And that I was very upset about, because the CNS team has expanded enormously, it's the largest team we've ever had, you know, and I've worked very hard on their job plans, they have allocated days for answering the phone, and it wasn't reflected in what I saw coming back.” (Consultant Nurse VN, Northbank Hospitals)

As a result of the survey VN introduced a number of changes: a new dedicated landline was established for patients wanting to contact a CNS; a new recorded message was placed on it giving the patient the number of a mobile phone they could call if they needed to speak urgently to a CNS; a new rota and set of responsibilities for answering the phones were introduced; as part of the rota a CNS would have the mobile phone at all times. Despite initial resistance from the nurses who were concerned that they would get more phone calls and that their other clinical work would be disrupted, their initial experience showed that the number of calls did not increase and, according to VN at the time of interview, they were much happier with the system and were saying ‘Actually it does work.’

This example shows that the results of patient feedback do influence actions that are taken to improve the quality of services. The focus in improvement is not on the subjective aspects of patient experience but on specific changes in the provision and delivery of services. The criteria and standards for improvement do not emerge simply and directly from the patient feedback or the way it is measured. The use of feedback is instead a result of the interaction between on the one hand the contents of feedback and the way it is measured and on the other hand a Trust's priorities and perception of its relationships with other services locally. In the case of cancer services, Northbank Hospitals Trust focused primarily on the development of a new

cancer centre and the relationships of the centre with other services locally, rather than on the standard of service as indicated by the Trust's position in the results of feedback nationally.

But this example also illustrates the fact that feedback from patients through surveys is also about the interaction between staff and patients. The response of staff to the feedback influences the actions that managers take to influence staff and improve the service. In Chapter 5 I will examine more closely the ways in which managers use feedback from patients to influence the attitudes and behaviour of staff. In the next section here I examine the use of national and local surveys in an initiative to improve food and feeding services at Hillside Hospital.

4.6.2 Food and Feeding at Hillside Hospital: Surveys, Regulation and Improvement

The example of cancer services at Northbank Hospitals has shown that service improvement resulting from patient feedback is influenced not only by the results of the feedback but also by the context in which those results are received and interpreted. The example of the food and feeding initiative at Hillside Hospital extends this analysis by showing how the use of feedback depends not only on internal perceptions and the standards incorporated in the measures of feedback but also on external environmental influences.

In this section I draw on three main sources of data: interviews with managers at Hillside Hospital; the results of the 2009 and 2010 national surveys of hospital in-patients and of the Trust's local How Are We Doing? survey; and information about the contents of regulations and the role of the Care Quality Commission as a regulatory body. My initial focus in examining these data was on statements by interviewees about the nature and origins of the initiative; I examined the additional data showing the context of the Trust's decisions and actions in order to identify the background to the strong opinions that were being expressed in interview.

It might be argued that feedback itself leads directly to the initiative to improve services. Early in fieldwork, in reply to a request for examples of where patient feedback had been used effectively in the management of services, Corporate Manager VF at Hillside gave the example of help with feeding provided by staff to patients. She talked about an initiative undertaken by managers at Hillside Hospital in 2010 and 2011 to improve the quality of food and the food service in the Hospital.

The initiative was undertaken in the words of Corporate Manager VF because of the results of the 2009 national in-patient survey:

“That’s definitely come from feedback, because we score in the bottom 20 percent nationally for trusts for help with feeding or patients having a perception that they’re not getting enough help. And that’s consistent. And last year it dipped again. So that’s very definitely you know ‘This is something we’ve got to tackle.’ ”
(Corporate Manager VF, Hillside Hospital)

The results of the survey go to everybody in the Trust. Directors and nurses will want to do something about it because in the words of VF ‘it looks pretty jolly dreadful really.’ The results of the 2009 national in-patient survey (of patients discharged in August 2009, surveyed by postal questionnaire between October and January, and the results published by the CQC in spring 2010) showed the Trust well down in the bottom 20% of trusts in England for the question about help with feeding; the results for 2010 (published in 2011) showed an absolute and relative improvement but the Trust still in the bottom 20% in England. In contrast with the response to the cancer survey at Northbank, the standards adopted here by managers at Hillside Hospital were explicit. The food and feeding initiative was on this account undertaken by the Trust because of the poor results compared to all other hospitals in the country in the national survey of in-patients.

As shown in the example of the cancer patient survey at Northbank, feedback and survey results are not in themselves a complete explanation for an initiative to improve services. Changes in statutory duties imposed on NHS bodies in relation to the nutrition of patients formed a significant part of the context for the establishment of the food and feeding initiative. Section 14 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 (which came into force in April 2011) imposed for the first time on the chief executives of NHS trusts (and other organisations) an explicit duty to protect service users from risks of inadequate nutrition and of dehydration, by providing suitable food and hydration and by providing support to service users to enable them to eat and drink. In 2010 managers at Hillside Hospital were aware that the Care Quality Commission was developing its inspection regime in relation to nutrition and hydration. The results of the 2009 national survey of hospital in-patients were published in May 2010 showing Hillside as having below average patient satisfaction rates for overall rating of hospital food and choice of food, and as being among the worst in England for providing patients with enough help with feeding. The survey scores and the new regulations contributed together to the

development of the food and feeding initiative. In the words of Allied Health Professional NE, who was the work stream leader for the food and feeding initiative at Hillside:

“ ... there is the added push of regulation, which means that we, we will be held to account more strongly perhaps on the nutrition front than we have been before. So it’s just become more important.”

(Allied Health Professional NE, Hillside Hospital)

The regulatory requirements on this analysis helped set the immediate context in which the patient feedback was received and used in the Trust.

The direct influence of regulatory requirements are not the only influence on the development of an initiative. Regulatory requirements and the inspectorial role of the Care Quality Commission also acted indirectly on the collection and use of feedback from patients. At Hillside Hospital in late 2009 an unannounced hygiene code inspection (itself according to information provided in interview by Governor JM in part prompted by information about the Trust given by governors to the Care Quality Commission) by the CQC found significant problems with cleanliness and breaches of the hygiene code. The Chief Executive was said by Governor JM to be very angry and ‘pulled out all the stops.’ The inspection resulted not only in a substantial set of actions by the Trust to improve cleanliness but also in a change of awareness that meant that the Trust’s directors and senior managers were much more sensitive than previously to the possible relationship between regulators’ views and patient feedback. Positive feedback would be recognised as positive; negative feedback might trigger an inspection and further actions from regulators. The Trust should therefore pay careful attention to negative feedback from patients.

The CQC hygiene inspection helped set the context for the Trust’s response to results of the 2009 national in-patient survey. The connection between the CQC hygiene inspection and the Trust’s response to the food and feeding findings in the survey was made explicit by Allied Health Professional NE in the Trust. He was talking about the origins and development of the food and feeding project in 2010, based on what had happened the previous year.

“Round about that time, just before Christmas, we had a spot check from CQC, about cleanliness. And we were castigated for dirty mattresses and all sorts of things. So when that result came along, we were, the Trust was acutely sensitive about any kind of patient experience, bad things with the service. So certainly, I’m sure that did have an impact on whether any resource was going to be put in

to this project or not.” (Allied Health Professional NE, Hillside Hospital)

The link between regulators’ actions and the use of feedback was also made explicit by Executive Director LS at Hillside. In reply to an interview question about the aims of collecting and using patient feedback, he talked about feedback from patients, the ‘very, very unhelpful’ CQC hygiene inspection, and the need to make improvements in services. The contextual awareness arising from the 2009 CQC hygiene code inspection was a contributory factor influencing the way in which the Trust responded to the results of the 2009 national in-patient survey in relation to food and especially help with feeding in the Trust and took action to improve the service. Trust managers’ awareness of regulators and of how regulators perceived the Trust influenced the managers’ use of patient feedback. CQC inspections acted in this example as a stimulus, directly and indirectly, to the ways in which managers took account of feedback from patients and the actions they took to improve services as a result of that feedback.

The food and feeding initiative originated in part from the results of patient feedback. Its effects were measured and monitored by the Trust’s managers in terms of feedback. The initiative in the Trust was approved by the Trust’s executive directors as part of the Trust’s Transformation Programme. It focused on improving food service in wards that had been identified in surveys as performing poorly in this area. Interventions included a small team of clinical and hotel service staff analysing and discussing (in a series of three meetings in each ward) problems and potential solutions about the availability, service and presentation of food, and about the help in reaching and eating food that ward staff were able to offer patients, with the nursing staff and ward hostesses in each ward. Progress with the initiative in each ward and division was monitored on a monthly basis by the project team using four sets of data: the results of two questions in the Trust’s How Are We Doing? survey; the results of a detailed surveys by the catering contractor focusing for example on choice and range of foods and on the quality, appearance, taste and temperature of the food; the results of the Trust’s own Foodservice Quality Survey based partly on observation and partly on talking to patients, and the results of Nutritional Risk Audits. The results of all these surveys were then aggregated into a single score for each ward and each division. The results were placed on the Trust intranet and publicised internally in newsletters and the intranet. Despite the detailed presentation to the Board of Directors in March 2011 saying how the initiative would be monitored, no further detailed information about the initiative or its results was presented to public meetings

of the Board in the year. Information in the monthly Patient Experience Report to the Board showed that the score for the How Are We Doing? question about rating hospital food remained at or just above the benchmark of 60 for the whole of 2011; the score for help with feeding remained just below the benchmark of 81 for the whole year. At this level of aggregation and reporting the initiative appeared to have little direct effect on patients' perceptions of the quality of food or the help they received with feeding.

This example shows that the results of patient feedback do influence actions that are taken to improve the quality of services. The focus in improvement is not on the subjective aspects of patient experience but on specific changes in the provision and delivery of services. The criteria and standards for improvement are identified in detail in a variety of questionnaires and survey instruments that record and measure feedback from patients. These measurements are reported in detail and used in the day to day management of improvement initiatives and services, but are reported only in summary to Boards of Directors. In the example of the food and feeding initiative at Hillside Hospital, the initiative appeared to have little or no impact on the overall rating by patients in the Hospital as a whole of food or the help they received with feeding. In Chapter 6 I will examine more closely what decisions Boards make and what else they actually do with the results of feedback that are presented to them.

4.7 Summary

In Sections 4.2, 4.3 and 4.4 I examined two contrasting uses of patient feedback: the use of feedback to improve patients' subjective experience of services; and the use of feedback to improve the quality and delivery of services as defined by service providers and managers. Managers sometimes see the purpose of collecting and using feedback from patients as being to improve patients' subjective experience, especially their emotional well-being and feelings of satisfaction as they use services. A focus on patients' subjective experience of services leads to a view, expressed in some government policy and by some managers, that it is patients' own assessment of the quality of services and hence of improvement, not the assessments of service providers, that is the most important test of quality. Other managers and government and Trust policy documents see the purpose of collecting feedback as being not to improve patient experience but to improve the quality and delivery of services as defined by providers and managers. For these managers patient feedback and patient experience are implements to be used to help improve services.

In Section 4.5 I analysed the ways in which the measurement and reporting of patient feedback in Trusts' formal reports reflects the use of patient feedback to improve patient experience and the quality of services. I showed that although Trust documents and reports frequently talk about 'patient experience' they only occasionally mention patients' feelings or the subjective aspects of patient experience. The focus in performance reports and quality accounts is on the numerical aspects of feedback from patient surveys as one indicator among many of Trusts' performance. This focus on the numerical aspects of feedback reinforces the view of patient feedback and patient experience as tools for improving the quality and delivery of services as defined by service providers and managers. Improvement itself is defined in terms of the numerical results of surveys and reductions in the number of complaints. I discuss the implications of these different approaches to the use of patient feedback in improvement in Section 7.2.1 in Chapter 7.

In Section 4.6 I analysed two examples of the use of patient feedback to examine how feedback is used in practice to improve patient experience and services for patients. The use at Northbank Hospitals of the results of the 2010 national survey of cancer patients showed that the numerical results of patient surveys are used to improve the quality and delivery of services, but that this improvement is limited by a wider set of perceptions about the importance of the survey results and their relation to other priorities nationally and locally. Analysis of the food and feeding initiative at Hillside Hospital similarly showed that the comparative numerical results of national patient surveys are used to initiate service improvements; but the use of this feedback again depends on the perceptions of managers and on additional external stimuli to action. The results of local surveys did not lead to actions to improve the service but were used to help target the initiative and measure its results. These two examples reinforce the evidence from the Trust reports and documents that numerical analysis of feedback from patient surveys is used by managers, in specific circumstances, to help improve the quality and delivery of services, as defined by managers in terms of the survey results themselves. But they also raise further questions about the actual impact of improvement initiatives and about the ways in which Boards of Directors themselves actually use the results of patient feedback, questions I address in Chapter 6. They also raise questions about the uses, if any, that managers make of feedback about patients' subjective feelings and experience of services; this is the starting point of Chapter 5.

Chapter 5 The Use of Patient Feedback: Influencing and Managing Staff

5.1 Introduction

I argued in Chapter 2 that the main purpose of collecting and using feedback from patients is to improve the quality and delivery of health services, but that there is very little analysis in the published research literature of the ways in which feedback from patients is used directly to influence and manage the staff who provide these services. I showed in Chapter 4 that managers use patient feedback not primarily to improve patients' subjective experience of or satisfaction with health services but to improve the quality of services in ways that are defined by service managers themselves, especially through the use of numerical scores of the results of surveys of patients. The purpose of this chapter is to examine how different kinds of patient feedback are used in different ways to influence the staff who provide hospital services. I will in particular ask in what ways, if at all, does the use of patient feedback to influence staff contribute to the improvement of services; is it used to influence patients' subjective sense of well-being or is it used to improve managerial aspects of service provision?

In Section 5.2 I examine the ways in which the subjective experience of patients is used to engage with staff and motivate them to improve the quality of the care they provide. In Section 5.3 I examine the ways in which broader sets of feedback, especially complaints and the results of surveys, are used in the training and management of staff. Section 5.4 analyses the use of compliments and positive feedback from patients to praise and thank staff; it also examines the implications of the use of this positive feedback for the establishment of explicit standards of service quality. In Section 5.5 I then examine the ways in which these different kinds of positive and negative feedback are used in practice in the context of a single clinical service, neurosciences at Hillside Hospital.

5.2 Patient Experience

I showed in Chapter 4 that one of managers' aims in collecting and using patient feedback is to improve the subjective experience of patients. But at the same time the specific changes that result from the use of feedback are usually described by managers in terms of improvement in the quality or delivery of services as measured by the numerical results of surveys of patients. In this section I examine

the ways in which feedback about the subjective experience of patients is used to influence the clinical and non-clinical staff who provide services. I examine whether feedback about patients' subjective experience is used by managers directly to improve services and whether it is used primarily to engage with staff and motivate them to improve the quality of the care they provide.

In this section I draw primarily on data from interviews with managers at Hillside and Northbank Hospitals. These interview data are set in the context of Department of Health policy guidance, especially about complaints and complaints systems. But, although some Trust documents talk (as I showed in Chapter 4) about the subjective experience of patients, I have identified none that explicitly relate to the use of feedback about the subjective experience of patients to influence or manage staff. My primary source of evidence is therefore what managers said in interview about how they used feedback and the detailed examples they gave about the ways in which the feedback had actually influenced staff.

There is very little in government policy or Department of Health guidance about the way in which patients' subjective experience should be used to influence staff or about the potential impact of this kind of feedback on staff. Some of the guidance tends to focus on the impact of negative feedback on staff. The Department of Health 'Understanding What Matters' guidance in 2009 acknowledged that negative feedback could be difficult for staff, but set it in the context of the potential for improvement.

"Negative feedback, while useful to the organisation, can be uncomfortable for staff and for managers. This can be overcome by making patient experience feedback an essential feature of everyday practice, and as a key quality improvement tool, and gaining widespread staff support for its use." (Department of Health (2009b) *Understanding What Matters*, page 12)

This acknowledges that complaints and other forms of negative feedback may not be easy for staff, but does not address questions of resistance or indifference to feedback. It suggests that 'discomfort' can be overcome by embedding feedback of all kinds in organisational culture and everyday practice, but does not suggest how this may be done at an individual or organisational level. This guidance thus said very little about the different practical ways in which patient feedback could be used to influence and motivate staff and hence improve the quality of services.

The Department of Health (2009a) guidance 'Listening, Responding, Improving' (issued in association with the Local Authority Social Services and National

Health Service (England) Complaints Regulations 2009) talked about complaints by patients as a result of mistakes by staff or service providers, but also suggested that this in itself presented an opportunity for improvement. The Introduction stated that part of the purpose of the reforms of the complaints systems was to:

“ ... encourage a culture that seeks and then uses people’s experiences of care to improve quality. ... Health and social care staff work very hard to get the job right first time but, with busy services, mistakes can happen. But if services can get their response to these mistakes right, the people affected are less likely to be unhappy and future problems can be prevented. ... When a mistake has happened, it is important to acknowledge it, put things right quickly and learn from the experience.” (Department of Health (2009a) *Listening, Responding, Improving*, page 6)

The passage here is interesting because it presents both the perspective of patients and other service users who are making a complaint and the perspective of health and social service staff who have to acknowledge and respond to the complaint as ‘experience’. It suggests an element of commonality between service user and service provider – the possibility of putting things right and learning from the experience. But, underneath this commonality, the focus on complaints as a consequence of mistakes, identifies the responsibility for actions that lead to complaints quite clearly with the individual members of staff involved, rather than with low standards, systemic failings, lack of resources or conflicts of priorities. The focus on the guidance is on the individual; the focus on the individual suggests that feedback may also be used to influence individuals.

Despite the lack of specificity in government policy and Department of Health guidance, the subjective aspect of patient experience and the emotional aspects of patients’ complaints are used by managers to influence and motivate staff. Service managers deliberately use individual patient feedback with individual members of staff; they also use it in team meetings and wider settings to engage and motivate staff. Divisional nurse manager IH at Hillside Hospital was asked in interview about how she handled complaints, whether she tried to get an overview herself or discuss them in a wider forum:

“I could answer a complaint, do the recommendations and the letter goes off to the people and nothing gets done. So that’s why I’ve been trying to get, occasionally, relatives or patients to talk to the ward, because I think it’s far more powerful hearing from them than

hearing from the head of nursing where they might think, 'Oh she's off again.' But, you know, so they hear how distressed the patient or relatives were, and getting them involved. ... And that's what I'm trying to show as well, we need to learn from this, do it differently. And our complaints are going down and the severity of the complaints is going down." (Divisional Nurse Manager IH, Hillside Hospital)

IH talked in the interview in some detail about the arrangements she made to bring patients and relatives back on to the wards to talk to nurses about what it was like to be a patient on the ward. She deliberately made sure that the nurses were exposed to the distress and other emotions experienced by patients. She used this exposure to engage the nurses with patients' feelings and hence increase their understanding of and involvement in changes in the quality of care that were needed. For IH the formal organisational processes associated with complaints and other kinds of patient feedback were often remote from clinical practitioners. She and other managers therefore sometimes made special efforts to bring home the nature and contents of patients' experience of services to clinical staff.

Feedback about the experience of patients is used not only in informal meetings and development sessions but also in the more formal training of staff. This training, at both Hillside and Northbank Hospitals, often involved role play based on case studies and actual examples of feedback from patients. I showed in Chapter 4.6.1 how the results of the 2010 national cancer patient survey were used at Northbank Hospitals to improve the accessibility of clinical nurse specialists to patients who needed information or advice. The results of the same survey and of patients' comments and complaints were also used to train clinic clerks and receptionists in cancer services. The training focused not only on the practical difficulties patients had in booking or changing appointments or speaking to staff but also on what it was like for patients. Consultant nurse manager VN at Northbank Hospitals talked in interview about an initiative to improve telephone communication about out-patient appointments and clinics for women with breast cancer.

"It's bad enough isn't it having worrying diagnoses and trying to negotiate your way through complex pathways of treatment, without having the added concerns of being able to get hold of people. So we actually ran an afternoon with the A and C staff and did lots of scenario work, role play around frustrations and he and I played out some different scenarios and then we got them to play some out as

well. And it was like, there was almost like a light bulb moment about half way through the afternoon when people suddenly began to click just how awful it was to be the patient on the end of the phone. Things improved enormously after that.” (Consultant Nurse VN, Northbank Hospitals)

The emphasis in VN’s account is on the worry and difficulties experienced by patients in trying to contact clinical staff: ‘how awful it was to be the patient on the end of the phone’. The first aim of the training was to get staff to see services from a patient’s point of view and to understand, both intellectually and emotionally, what it felt like to be a patient using the services. The understanding and acceptance of this experience then formed part of the basis for service improvements, in this example at Northbank Hospitals as in the previous example at Hillside Hospital. This evidence shows that managers use feedback about patients’ subjective experience of services, both in informal staff development and in more formal training sessions, to engage with staff and motivate them to change the quality of care and the ways in which they provide services.

The subjective aspect of patient experience and the emotional aspects of patients’ complaints are used in these ways by managers not only to influence and motivate staff but also as a starting point for further patient involvement and improvements in services. The emotional impact of patients’ experience is a starting point for motivating staff that then leads to changes in the ways in which staff provide services. Nurse Manager IH and Consultant Nurse VN in the previous examples both said that the actions they had taken had an effect on the staff they were targeting. Corporate Manager WR at Hillside Hospital talked in interview about a patient with a brain tumour and his wife who had made a complaint about the quality of care on one of the neurosciences wards.

“We received a very sad complaint last year written by the wife of a patient who – they were obviously very traumatised by his experience in hospital. And you could tell by – not just the size of the letter – but just the way it was written, that it was obviously – it pained them quite a lot to have to write it. ... We had one meeting. And it was clearly very emotional. ... Nursing care on that particular ward at that particular time was not good.” (Corporate Manager WR, Hillside Hospital)

What WR emphasises here is the emotional content of the feedback – the distress – combined with the substance of the issues. Managers recognised the deficiencies in

the service, both for the individual patient and more generally. Following a further meeting with the divisional nursing manager and complaints manager, the patient and his wife were asked to return to the ward and talk to the nursing staff.

“And actually the couple actually returned to the Trust after our meeting and met with the nursing staff and told them exactly how their experience had been, first hand, heard them, and that was very powerful, and was hard for some of the nurses to hear. But it was great. And they also came and got involved in rewriting parts of the patient information booklet for this gentleman’s particular condition.”

(Corporate Manager WR, Hillside Hospital)

In this example, which I examine further in Section 5.5, the experience of the patient was hard for nurses to hear; the underlying value for those nurses and for WR was that the patient’s experience should have been better. A difficult experience for a patient was transformed into a difficult experience for staff. Feedback about the experience was used by managers to help change staff attitudes and to prepare for specific service changes.

The examples in this section so far have focused on the influence of the subjective aspects of patient experience on nursing staff and nursing care at ward level in individual services and on clerical staff and receptionists in out-patient clinics. Managers also use the subjective aspects of patient experience and individual patient stories more widely to motivate and influence staff. Some of the context for the management of NHS hospital trusts has been set since 2009 by the severe failings leading to the avoidable deaths of patients at the Mid Staffordshire Hospitals NHS Foundation Trust. Executive director LS at Hillside Hospital had recently used his own experience, talking to one patient during a directors’ ‘Go and See’ visit to the medical wards for the care of elderly patients in the hospital, in one of the regular quarterly senior leaders’ meeting with about 75 of the senior clinical staff and managers in the Trust. The patient to whom LS had been talking had, after initially bursting into tears and refusing to speak to him, told LS that he was being bullied and neglected by the nursing staff at night in his side room on the ward – being told by a nurse to empty his own commode: ‘You’ve got legs. Empty it yourself.’ In interview LS was asked what he was using this example for in the senior leaders’ meeting:

“I was using it to try and remind people that we need to be, continually be on the lookout for improvement. That we should you know never be complacent. We can’t be everywhere all the time. The systems hide a lot of things. And we need to respond, you know

we can't sweep something like that under the carpet, otherwise everyone thinks it's OK to sweep it under the carpet. And I was really doing it to invite participation. And of course if you've got a room full of doctors and nurses, they're most likely to become energised and interested in the meeting if you talk about patients ..."

(Executive Director LS, Hillside Hospital)

This extract indicates that LS had a complex, possibly deliberately unclear, mix of motives. He talked about avoiding complacency, setting and maintaining standards, avoiding relying on systems, engaging clinical staff and managers, and getting them to improve the quality of care for individual patients; he emphasised his efforts to engage and motivate staff. In telling the story in the senior leaders' meeting and in interview LS himself emphasised the personal, individual character of the patient and the distress he (the patient) had experienced. As one of the most senior managers in the Trust, with responsibilities for all aspects of the services, staff, finance and operational performance of the Trust, LS deliberately and explicitly focused the attention of senior clinical and managerial staff on the emotional experience of one individual patient and its implications for the quality of care.

The intention of LS in this example was to engage with consultant medical staff and other senior managers, to motivate them to think about the relationship between individual patients and the quality of services more generally. He had a substantial impact on senior managers and other staff. Several managers interviewed for this study mentioned the senior leaders' meeting.

"LS used that very powerfully in our senior leaders' day here, talking about an elderly patient on the wards that he had spoken to. And to be honest I've never seen – well I would never have expected LS to do it – he's quite a tough man – but you know nearly in tears in front of us lot about what this patient had said to him, and he considered it a failure of – his failure – that that happened in his hospital. That real heartfelt type of thing I mean it made me sit up." (Corporate Manager RP, Hillside Hospital)

RP's comments here focused first of all on LS's personal response to the circumstances of the individual patient and the quality of care that he received. RP emphasised LS's sense of responsibility for that care and his sense of personal responsibility for the failings in that care. The link in this example is between the difficulties experienced by the individual patient and the responsibilities of the individual manager. This connection is then communicated to senior clinical staff and

managers, not simply as a matter of organisational fact, but as something that is personal and emotional – ‘heartfelt’ – in itself. The communication of patient experience was used to energise senior managers and clinicians, to make them ‘sit up’. Individual patient experience can be used, as in this example, to influence and motivate staff in ways that may not be achievable through the use of performance indicators and management scorecards.

All the examples examined in this section are clearer and go further than government policy and Department of Health guidance in identifying ways in which feedback about patients’ subjective experience of services can be used, and is used, to influence clinical and non-clinical staff providing hospital services. DH guidance implies that Health Service staff should be motivated to provide high quality services but the pressures of working in a busy environment may lead to mistakes and negative feedback in the form of complaints. The examples quoted here show that the subjective aspects of patient feedback, the fear, distress and anger experienced by patients, are used deliberately by managers to engage with a wide range of clinical and non-clinical staff in hospitals and to motivate those staff to improve the quality of service that they provide for patients.

5.3 Staff Improvement: Learning, Training and Management

I have shown in the previous section that the subjective aspects of patient experience are used by managers to engage staff with patients’ view of services and to motivate them to improve the quality of care they provide. The example of the clinic and reception staff at Northbank Hospitals also showed that feedback about patient experience is used more formally in the training of staff. In this section I examine the ways in which managers use feedback from patients more broadly to influence staff and improve services. I will examine the ways in which different kinds of feedback, especially complaints but also the results of surveys, are used in a wide range of settings in the training of staff, in regular service meetings with staff to influence the quality and development of services, and in the more formal processes of managing individual members of staff.

In this section I draw again primarily on data from interviews with managers at Hillside and Northbank Hospitals. I have little evidence from the Trust documents made public through meetings of the Boards of Directors or the Trusts’ websites about the use of patient feedback in the management of staff; this is an issue that is more likely to be considered in internal meetings and management documents that I have not accessed in this study. The interview data are however set in the context of

Department of Health policy documents and guidance, relating especially to complaints, and also in the context of the NHS Constitution.

Government policy and Department of Health guidance sometimes implies that feedback from patients will influence staff but says little about the different ways in which this may happen and gives few specific examples. Following consultation and the publication by the Department of Health of 'Making Experiences Count' policy documents in 2007 and 2008, Parliament approved The Local Authority Social Services and National Health Service Complaints (England) Regulations 2009, which then formed the legislative basis for NHS complaints procedures in 2011. The Making Experiences Count consultation and policy documents in 2007 marked a change in policy from an emphasis on due process and a quasi-judicial 'response' to complaints to seeing them as a source of feedback that could be used to improve services. The primary purpose of these regulations was, according to the Explanatory Memorandum, to align NHS and adult social care complaints processes into a single set of arrangements. In addition the Regulations removed some of the prescriptive elements around the timescales for the consideration of complaints; this according to the Explanatory Memorandum:

“ ... allows organisations to assess and deal appropriately with all complaints, allowing these arrangements to meet the needs of the individual case and for proper consideration of learning and service development issues.” (*The Local Authority Social Services and National Health Service Complaints (England) Regulations 2009 Explanatory Memorandum*)

Despite the fact that the primary legislation and the Regulations continued to focus exclusively on the procedural aspects of the handling of complaints, the broader context of policy and the ways in which those procedures were reformed meant that information about complaints was seen as a source of feedback to be used to improve services. As part of this objective, organisations and by implication their staff would 'learn' from complaints about the issues of concern to patients.

The subsequent Department of Health guidance (Department of Health (2009a) *Listening, Responding, Improving. A Guide to Better Customer Care.*) developed in more detail the concept of complaints as a source of feedback that staff would use to improve services. The section of the guidance on 'Improving' related both to improving the handling of complaints and to improving services on the basis of information gained from complaints. Improvement was set partly in the context of 'Improving customer focus' and 'What makes a happy customer?'. In the passage

from page 36 of 'Listening, Responding, Improving' (Department of Health 2009a) that I quoted in Section 4.3 on page 101, the guidance focused for the first time in government policy or Department of Health guidance about complaints on different kinds of feedback – comments, compliments and concerns, as well as complaints. It also was unlike earlier DH guidance about complaints or patient feedback more generally in that it addressed NHS complaints managers and other service managers directly 'You can use any comments ...to tell you what's working ... to provide the information you need to review your services ...'. This for the first time directly identified and involved managers as members of staff in using patient feedback to improve the quality of services; it personalised managers' involvement in the use of feedback. The passage also talked for the first time not simply about 'learning' or 'quality improvement' in general terms; it spoke specifically of using feedback for staff improvement. In all of these ways the Listening, Responding, Improving guidance presented a distinct change in DH thinking about the use of patient feedback; the focus was more clearly now than previously on the use of feedback to improve the way staff carried out their responsibilities and as a result improved the quality of services.

The NHS Constitution (Department of Health 2009c), following the pattern of earlier policy documents, explicitly used the term 'feedback' from patients, but like them did not define it. The NHS Constitution did set out in broad terms, in the context of rights and responsibilities of staff and patients, something of the nature and use of feedback. It identified responsibilities of patients and staff; staff should aim:

“ ... to be open with patients, their families, carers or representatives, including if anything goes wrong; welcoming and listening to feedback and addressing concerns promptly and in a spirit of co-operation.” (Department of Health (2009c) *The NHS Constitution*, page 11)

NHS values include a commitment to the quality of care:

“We welcome feedback, learn from our mistakes and build on our successes.” (Department of Health (2009c) *The NHS Constitution*, page 12)

The commentary here highlighted, unlike much earlier policy, positive feedback as well as negative comments and views, building on successes as well as learning from mistakes. Feedback is to be used not in the (potentially negative) context of performance management but in a spirit of cooperation, learning and building on successes. Feedback was in this way seen as part of a developmental process, for

staff and organisations. It is the responsibility of staff (not just of NHS organisations in the abstract) to recognise and respond to feedback and to use it to improve services for patients.

I showed in Section 5.2 how feedback about the subjective experience of patients is used by managers directly to engage with staff and motivate them to improve the quality of service they provide. Evidence from interviews shows that this subjective experience of patients is also used directly in the more formal training of patients. Videos and summaries of individual patient stories are used in induction training. Much training is based more directly on individual patient feedback than on the results of surveys. Patients are sometimes explicitly involved as teachers. They tell their stories and talk about what it is like actually using services. An example (involving relatives rather than patients themselves) about care at Northbank Hospitals for patients who are dying.

“So people that have an interest in end of life care. And it was a whole day of training for them. So some of it was around sort of, you know, the basic kind of, you know, syringe drivers and, but they also invited other people. So the, one of the chaplaincy came to talk about spiritual care. And then we had service users who came and told – and actually presented their stories. And they were quite early on in the day. And it was very powerful, there were tears from the staff and the feedback I got was how powerful it was and how it changed the focus of the whole day. And it was sort of talking about patients, they actually kept referring back to those experiences.”

(Project Manager NM, Northbank Hospitals)

In this example it was the experience of patients and their relatives, directly recounted by the individuals involved, that has the most impact on staff. This experience was set by trainers alongside the professional and technical aspects of caring for dying people, but it was the experience of patients and relatives that itself set the context for much of the discussion about more technical issues. The experience of patients had a substantial emotional impact on nurses and other clinical staff providing care for people who are dying. The example shows that the experience of patients and relatives and the emotional impact can form an integral part of the training of and learning by clinical staff

Managers sometimes find the detail in individual complaints or the analysis of a small number of complaints more informative than summary statistics. Managers' ability to look at and consider the specifics of individual cases is crucial. In one

example of a complaint that was discussed in interview, the patient and his wife identified at least three sets of issues: the quality of care for incontinent patients, the provision of information about a particular medical condition, and the attitudes and communication of ward staff. The wife also made general judgements about the quality of care on the ward. Managers said in interview that it is very difficult to encapsulate this diversity of information in a coding framework that then serves as the basis for the statistical analysis of complaints or comments. They obtain a better understanding of the issues by reading individual complaints letters.

“What I tend to look out for are themes that may not be picked up by the, the centralised data collection, because it’s more obvious to me from the nuances in the letters, what the themes are, so I might see – oh we’ve got a flurry of complaints about a certain area.”

(Divisional Manager GC, Hillside Hospital)

GC talked in interview about reading two or three complaints about a particular ward that then raised questions in her mind about the overall quality of care and approach of staff in that ward. This evidence shows that the detailed information from complaints helps managers identify specific areas of concern, about individual members of staff or about groups of staff more widely. It is the detailed information that helps them identify more general themes that they can then use to work with staff to change the way staff work and improve services.

Managers expect staff to learn from complaints and improve services. Evidence from interviews shows that the focus is not only on individuals but also on teams of staff. It is about learning and expectations. Complaints are a source of improvement for staff.

“ ... initially I used to think complaints are so negative, initially. But then when I heard aspects of, you know, issues that patients address and I thought, well how about making those aware to the team, so that we improved in those areas, we will have definitely gotten better. ... So when someone says ‘complaints’, I’m like, ‘OK that’s a huge training opportunity for the team!’ ... But equally if I have ensured that my team has completely learned from every complaint so far, then I do not expect to see any further complaints coming through on to my desk!” (Ward Manager RE, Hillside Hospital)

Here RE contrasted her own former attitude to complaints, as negative criticism that requires a lot of work to answer, with her current attitude, seeing complaints as an

opportunity for learning and improvement. But the opportunity did not exist in isolation; she expected staff to learn; there should be no more complaints about that issue. For RE at the most straightforward level, the fact that a complaint was made was an indicator that the service needed to improve. Improvement had taken place when there were no more complaints. The number of complaints formed a standard by which the service and, by implication, the staff were judged.

Senior clinical staff with management responsibilities and clinical service managers use feedback in the form of comments and complaints to address issues with individual members of staff. Criteria and standards of improvement relate to specific clinical conditions and procedures. Sometimes this is quite straightforward from the manager's point of view. It may simply be a question of a new member of staff not knowing about local priorities or procedures. Consultant physician RG talked in interview about the kinds of issues that might be raised with her in consultation by individual patients.

“ ... one of the patients said to me, ‘Well the specialist registrar, but they didn’t do a full gynaecological examination, whereas you always do. And I wondered why that was.’ So I mean that was something that I could take back to the registrar to say, ‘We normally do a full examination, not just part of it and that’s what the patients expect when they come for follow up.’ So I mean I guess it’s, so I must say, you know, the registrar took that on board and it was excellent after that. And I guess it’s something I’d not realised to explain to them what they needed to do.” (Consultant Physician RG, Northbank Hospitals)

Here the feedback was a simple comment and question about clinical practice from a patient to a consultant as part of a clinical interaction. The consultant, being the senior member of staff, talked about it to the specialist registrar who was working under her supervision as part of her team. She explained her expectations and the SpR changed the way she examined patients and carried out her responsibilities. The feedback from the patient was used in this example as part of the training of a junior member of staff.

It is not simply that staff are expected on their own to learn from patient feedback. Managers use patient feedback to identify needs for training; they use feedback in the training of staff. Managers at Hillside and Northbank Hospitals gave examples in interview of the ways in which complaints from patients, the results of surveys and other forms of feedback had been used, alongside other information, to

initiate training for clinical and non-clinical staff. A substantial example described in interviews at Northbank Hospitals related to the care of elderly people in general medical wards.

The focus in the initiative about the training of staff working on the medical wards for the care of elderly people at Northbank Hospitals was primarily on the attitudes and communication skills of staff; it therefore also spread into wider issues about the quality of care and relationships between patients and staff more generally. Training was provided for nursing and for administrative and clerical staff working in wards and clinics. The training focused on teams of staff at an individual service level in the Trust, rather than on particular individuals. Corporate nurse manager NT at Northbank Hospitals described the influence of feedback on the training of nurses and other ward staff:

“... the biggest impact, I think the positive impact on the shop floor will be in elderly care and medicine where especially elderly care we had few complaints, but they’re bad. And it’s at the ABC, I call it, attitude, behaviour, communication, the same stuff that comes up. And actually, you know, so the numbers might be tiny and when you read them, they’re as bad as the Ombudsman’s Report, you know. So what we’ve done with the feedback, with the Ipsos MORI and with other intelligence, is we’re actually closing those wards two weeks at a time and putting all the staff through a development programme.” (Corporate Nurse Manager NT, Northbank Hospitals)

In this example NT and other managers in the Trust emphasised the scale of the organisational changes and the impact on income and resources of closing each of the busiest wards in the hospital for two weeks at a time in order to train staff and improve the quality of services. The focus of the training according to NT was on staff attitudes, behaviour and communication, but underlying this was a deeper concern about the overall quality of care on the wards. Although the concerns that prompted the identification of the needs for training arose in part from complaints, it was not in this instance simply the number of complaints that was important; it was also the importance and severity (as judged by reference to the Health Service Ombudsman’s report, an authoritative external source of information) of the particular issues raised in the feedback that led to action.

Something of the way in which different kinds of feedback interact to influence managers’ decisions about the training of staff and improvement of services can be identified from this example. I have highlighted NT’s statement that it was the severity

of a small number of complaints that led to action. He also set the decision to close the wards for training purposes in the context of the Trust's local Ipsos MORI quarterly telephone survey of patients.

“And that's not just on the Ipsos MORI, but the Ipsos MORI has added to that, because I went to the Chief Nurse with the Ipsos MORI results and said, 'There you go, red, red, red, red, red – just for those CQUIN questions mind – but those CQUIN questions are important.' And she said, 'Well, we're going to close the wards.' ”

(Corporate Nurse Manager NT, Northbank Hospital)

As I showed in Chapter 4.5 the colour coding of survey results provided for managers an immediate, visible way of identifying and highlighting issues arising from patient feedback. But the additional information given by NT here set these red survey results in the context of the Trust's CQUIN targets agreed with local commissioners. The training of staff arising from patient feedback about attitudes, behaviour and communication and about the quality of care more generally was set in the context of patients' complaints and an Ombudsman's report and of survey results and CQUIN targets. The aims of training staff and improving the quality of services appear in this example to have resulted from a complex interaction of internally and externally generated criteria for improvement and standards of service.

Feedback from patients not only leads to training initiatives with staff; it is also used as part of the training. The training may at quite a general level, to help new staff understand the expectations placed on them when they come to work in the organisation as part of a Trust or local induction programme. Executive Director AT at Hillside Hospital was asked in interview whether patient feedback fed directly into the training of staff.

“Yes I think it does. ... to take account of behaviours that our service users experience when they come in to the organisation. And that starts right at induction. So this morning, I was the director delivering the corporate welcome. And we, we have a number of videos that we use, and then I speak to a presentation in which I am very keen to help new members of staff coming here, understand their role in making service users welcome and feeling that they're supported and reassured when they come in to the environment.”

(Executive Director AT, Hillside Hospital)

The induction training described by AT drew in general terms on what patients said about the hospital. The videos and presentations emphasised the importance of

positive behaviour and good communication with patients; they emphasised the Trust's values 'understanding you: listening to each other; listening to patients; knowing what's important to them.' Although the aim of this induction training was different from the remedial training described in the previous paragraphs – the aim of the induction training was to help new members of staff understand the standards of behaviour and ways they should behave with patients, the aim of the remedial training was to try to ensure that staff changed the ways in which they have been behaving – the underlying criteria and standards were the same. Both sets of training were about helping patients and treating them with care and respect while they were in the hospital, the interpersonal interactions and relationships between staff and patients.

The form and contents, as well as the results, of feedback are used in more detail in local induction schemes for new staff in individual wards and departments. The How Are We Doing? survey of patients was a major source of patient feedback at Hillside Hospital and part of the management systems within the Trust. The questions in the survey helped identify the standards of care and service to which staff should work. These survey questions were used in the induction and training of new staff.

“And I must admit that as, when we have new staff into the Trust, it's one of the bits of paper that I also show there, to sort of say that these are the things that we're marked on every month, and these are the things that again you need to be aware of when dealing with patients.” (Nurse BJ, Hillside Hospital)

Unlike Executive Director AT, who presented the survey in a positive light in the context of the Trust's values, Nurse BJ here appeared to present the survey in a more ambiguous way: 'these are the things we're marked on every month'. The criteria and standards incorporated in the reporting of the survey results were for her decided by other, more senior, managers in the Trust. They were something given to nurses and managers working at ward level. The focus of this part of the induction training was in BJ's account first of all on the three main headings used in the How Are We Doing? survey: patients' engagement in their care; the ward environment; and patients' perceptions of care, and then on the individual questions used in the survey. The focus was therefore largely on the actions staff take and how they behave while they were providing services for patients. The standards of behaviour, which were discussed when managers and new staff looked at the survey results for their ward, were those incorporated in the Trust's benchmarks and reflected in the colour coding of the results.

Feedback from patients is used not simply in the training of staff but also, along with a wide range of other information, in the more direct line management of staff. I have shown earlier in this chapter how feedback is used by front line managers – especially nurse managers – to help set standards of care and service delivery on wards. Sometimes using feedback with individual members of staff is difficult, as acknowledged in the Department of Health's (2009b) 'Understanding What Matters' guidance discussed in Section 5.2. Negative feedback can be uncomfortable for managers and staff. A variety of examples mentioned briefly in interviews show that standards and feedback relate not so much to specific clinical procedures and junior members of staff as to the attitudes and behaviour of senior clinical staff, doctors and nurses alike: time of arrival at clinics; the way in which they speak to patients; talking to other staff in front of the patient. Managers in interview recognised that there may be individual personal issues to be addressed. Organisational relationships were not always as straightforward as the relationship between a consultant and trainee. This required a considered approach by the senior manager.

"I mean I guess my management style of feeding this back is very much, 'Well we've all got to concentrate on doing this.' And then, you know, I realise that if that doesn't work, you do have to take it on board with an individual consultant. And, you know, it's one of those thing that does make all feel uncomfortable, I think, but I do feel it has to be done. And I guess that's changed as I became, took on a management role." (Consultant Physician RG, Northbank Hospitals)

Here RG identified a two stage approach to raising issues arising from complaints or other kinds of feedback with consultant colleagues: having a general conversation with colleagues about particular issues; and speaking in private to an individual consultant about his or her own behaviour or actions that had been the subject of negative feedback. Addressing issues with individual colleagues might not have been easy for RG; it was a skill that she learnt as part of a management role. The example indicates that the way in which feedback is used to effect change with particular individuals is influenced both by the nature of the issues raised in the feedback and by the roles of and relationships between the managers and members of staff involved.

The relationships between managers and other staff may influence whether or not substantial action is taken to address issues raised in feedback. Evidence from interviews suggests that the standards of behaviour that are implicit in a manager's

decision to take action on the basis of feedback are determined in some circumstances as much by the organisational relationships in which the manager is working as by any general policies or criteria relating to the standards themselves. Executive Director GH at Northbank Hospitals talked in interview about the way in which ward managers might be deterred, from taking action with a member of staff who had been the subject of a complaint from a patient, by the prospect of that member of staff taking out a grievance against the manager.

“And then you know the ward sister trying to manage that person is then on the receiving end of requests for statements and so forth. And so that can put them off: ‘Why would you do that management in the future?’ So there’s a lot of layers that we have to understand.”

(Executive Director GH, Northbank Hospitals)

The point that GH made here was that ward sisters and other first line managers might be deterred from raising with an individual member of staff an issue resulting from a complaint or other kind of feedback from a patient because of the subsequent conflict and difficult managerial relationships in which they might be involved. An individual member of staff with whom a manager had had a discussion or begun a performance management process because of a complaint might take out a grievance for harassment or discrimination. This would then create extra work for the manager and put the manager’s own position in the organisation at risk. The simpler approach for some managers, according to EE, was to avoid the risk of conflict and not address issues with the member of staff. Although senior managers and directors might have policies about acceptable standards of behaviour, the consequences for front-line managers of taking action on the basis of feedback from patients, which might itself be contested, sometimes outweighed the benefits of trying to get members of staff to adhere to those standards.

Senior managers sometimes use information about complaints from patients to challenge individual members of staff about their standards of care and behaviour. Although this study has not collected detailed data about the extent to which managers use feedback from patients as part of the regular management and performance review of individual members of staff, it appears that this feedback is, in certain circumstances used as part of the formal processes of managing staff. Corporate manager CS at Hillside Hospital talked, in the context of an example drawn from the neurosciences, about the way information from complaints made by patients was used by clinical teams and departments.

“Mostly it’s at a sort of educational staff meeting issue. Sometimes there have been issues that have related to individual staff where you may or may not hear that further action is ensuing, which may be of an educational or disciplinary nature, depending on whether there’s any history.” (Corporate Manager CS, Hillside Hospital)

The primary point made here by CS was that complaints by patients might in certain circumstances lead to direct managerial intervention or disciplinary action with an individual member of staff. The secondary point was that she herself, as a member of staff of a corporate department in the Trust that was not directly involved in that managerial action, might or might not hear about the action that had been taken. Although managers did not necessarily publicise within the Trust actions that they had taken to manage or discipline individual members of staff on the basis of feedback from patients, CS’s comments indicate that feedback was in fact used in these ways.

Senior managers were, without giving in interview details of the disciplinary issues or actions taken, more explicit than corporate manager CS about their involvement and actions in the neuroscience services. I examined in Section 5.2 of this chapter the example of Executive Director LS who had used his personal contact with an elderly patient who was receiving an unacceptable quality of care on the ward at night as the basis for a discussion with the senior leaders in the Hospital, to motivate them and encourage them to be vigilant about the quality of care. LS gave more details about the results of the episode. As a result of this episode, senior managers ‘changed the ward team’.

“We changed the ward manager and we changed that particular member of staff, who’s actually left. That particular member of staff only worked nights. So the ward manager didn’t know her. So ‘What do you mean? You’ve got staff that you don’t know?’ So. Yeah. So we did it.” (Executive Director LS, Hillside Hospital)

LS here said that the individual nurse who had been said by the patient to be uncaring and bullying had left the Trust; the ward sister had been moved to another job in the Trust. The implication here, taken with information from other interviews, is that divisional managers and the Trust’s executive directors working together moved both the individual member of staff and the ward manager to different posts within the Trust. The individual member of staff subsequently resigned from the Trust. Feedback from an individual patient led, in the context of a service about which senior managers already had substantial concerns arising from complaints and the results of surveys of patients, led in this example to significant changes in the nurse staffing

of a ward. The example here, along with evidence I examine in Section 5.5 about the neurosciences at Hillside Hospital, shows that feedback from patients is used directly in the management, as well as the training and development, of staff.

5.4 Praise: Morale, Motivation and Service Standards

I have shown in the previous sections that patients' subjective experience of services and information from complaints and surveys are all used by managers in the training and management of staff to improve the quality and delivery of services. The emphasis has been on improvement where the current standards of care and provision of services have not been satisfactory. In this section I examine the ways in which praise and other forms of positive feedback are used in the training and management of staff. I address the question of how managers use positive feedback: do they use it to highlight good practice and set standards of service for staff to follow; do they use it to improve services; or do they use it for other purposes?

In this section I draw on evidence from interviews with managers at Hillside and Northbank Hospitals. This interview data is supported by my analysis of Trust documents, especially the staff commendation scheme nomination forms and other documents that set out the formal criteria by which nominations from patients and other people are assessed. The interview and documentary data are also supported by my observation of staff commendation awards ceremonies held in the presence of Boards of Directors immediately before the meetings in public of the Boards.

Positive and negative feedback do not exist in isolation. Although complaints are by definition negative in their content, most forms of feedback may be either positive or negative. Some feedback, in the form of suggestions for improvement, are both negative in the sense that they identify something wrong with a service and positive in that they suggest something that could be improved. Managers are in interview explicit about the relationship between the use of negative feedback and the use of positive feedback. Negative feedback can be used as the basis for improvement or for blame. Positive feedback can be used for praise or to support further improvement.

"We will say, 'This is the number of compliments we've had this month,' I think it's really important to balance it out, when we've had negative stuff as well. We actually say, 'These are the good parts of the service.' I suppose when I first came back here, the culture of this team was very much blame, and there was, it was very negative, it was about everything that was going wrong. ... Nobody

ever thanked anyone, no one ever said, 'Thank you for all you've done.' ” (Consultant Nurse VN, Northbank Hospitals)

The starting point for VN here was the previous emphasis in the cancer nursing team on negative feedback; on things going wrong that needed to be improved. She acknowledged that some of this negative outlook still remained in the service but also said that she and other managers had worked hard to identify positive feedback, to communicate it explicitly to staff, and to thank staff for their hard work and the efforts they had made to provide a good quality service. She said that she and other managers now identified and used negative and positive feedback alongside each other for different purposes. Positive feedback was, alongside the need for improvement, part of the story.

Evidence from interviews and my informal observation as I was being shown round wards in Hillside and Northbank Hospitals shows that thank you letters and other positive comments from individual patients that are received by managers are communicated to the staff involved and distributed more widely. Positive feedback in cards, letters and thank you notes was placed in ward communication folders and put up on notice boards for everyone to see. This feedback was not only in the form of surveys or statistics but was very often about individual patients' episodes of care. When the feedback identified a particular member of staff managers ensured that it was communicated to that person. Managers also circulated positive feedback more widely to members of their team or department. From the perspective of a clinical director:

Interviewer “What route do the compliments that you see come into you from? Where do they come from, please?”

EE “In writing. So I think usually if a patient is sending a thank you card, it will go directly to the clinical area they wish to. But occasionally we get letters sent to the Chief Executive or emails that we then pass on to the teams, to the named staff.” (Clinical Director EE, Northbank hospitals)

And similarly:

Interviewer “Compliments, compliments come in, in what kind of routes? What happens to them please?”

EW “I guess most patients write a card to the ward and leave a box of chocolates and something like that. And then if somebody writes a letter – anyone pretty much, so if they write a letter to the consultant saying, 'Thank you for your care and also thank you to

all the ward nurses,' then I generally get a copy of that and I try and make sure it's cascaded back down." (Divisional Nurse Manager EW, Hillside Hospital)

Both examples here identified a process of cascading of thank you letters and praise for staff. Patients sent these kinds of positive feedback to different people in trusts, to the chief executive, director of nursing, consultant medical staff, ward managers and others. These managers had their own distribution procedures and lists, depending on who was mentioned in the feedback. Compliments that identified specific individuals were sent to those members of staff. At ward level thank you letters and cards were put up on staff notice boards for all staff to see and read. Positive feedback was regularly distributed and publicised by managers within wards and clinical services in broad terms to thank or praise staff. But, although managers spoke in interview about the receipt and distribution of thank you letters and praise from patients, they usually did not talk in any more detail about additional aims that they were trying to achieve; praise appeared to be an end in itself.

Some evidence from interviews shows that positive feedback is sometimes used in much more specific ways. Feedback is used in the professional development of clinical staff. Thank you letters and praise are communicated to doctors and other clinical staff in the expectation that they will use them in their portfolio for their annual appraisal. From the perspective of a nurse manager:

Interviewer "If a compliment comes in to a named ward manager or a consultant or somebody, how does that collection process work?"

VN "So they photocopy them so they can keep them for their own portfolios and things as they all do ..." (Consultant Nurse VN, Northbank Hospitals)

From the perspective of a consultant

Interviewer "Thank you cards, letters, the compliments, the positive kind of things – how do those get shared or disseminated out?"

RG "Yes, so quite often they come to the consultant in charge of the team. But I must say what I do when – if they do say to the team, it depends how the letter's worded but if it mentions a specialist registrar, I tend to photocopy it so they can have it for their portfolio." (Consultant Physician RG, Northbank Hospitals)

And from the perspective of a senior consultant involved in the training of junior medical staff, individual examples of positive feedback are not only included in an

individual's portfolio but positive and negative feedback may be used more generally as part of an individual doctor's appraisal.

"So, in the informal situation they will be passed on 'Mr Bloggs thought you were excellent. Well done.' Or, one of the registrars may be taken aside and told that what they did didn't work well, and they need to think about that. In a more formal setting the, all the junior doctors will go through an appraisal of their training and those sorts of things whole individually won't necessarily be fed back, they will as a whole be fed back." (Consultant Surgeon BS, Hillside Hospital)

This interview evidence shows that praise and positive feedback were used by individual doctors as part of their personal and professional portfolios. Positive feedback from patients, as well as the negative feedback that I examined in Section 5.3, is used as part of the formal appraisal process of doctors and other clinical staff.

The results of patient surveys at Hillside are distributed and publicised for staff by managers within wards and departments. Again, the interview evidence tends to suggest that this was done as part of regular management practice, without necessarily identifying specific aims each time the results are distributed. The results of the survey each month were made available to all staff on the Trust's intranet. Printed copies of the survey questions and scores were put on ward notice boards where members of staff, patients and visitors could see them.

"In relation to the How Are We Doing? survey we have a notice board which is outside my office. And every month when the results come out we actually put the sheet up on the board. So that's there both for patients, relatives and staff to actually see." (Nurse Manager BJ, Hillside Hospital)

The intention was that the results of the survey would be part of the everyday working environment on the ward. Positive and negative feedback was available for everyone to see. But there might be differences in the way positive and negative feedback was presented to staff on wards. The results of the How Are We Doing? survey were discussed each month at ward team meetings and the scores put up on notice boards in the wards.

"Notice board, copy on the desk so they can actually read and a copy in one of our communication folders. And I have requested for a colour copy because ... this time it's majority of the greens I have

ever seen in my two and a half years. So I'm absolutely thrilled to bits." (Ward Manager RE, Hillside Hospital)

According to RE the survey results were routinely pinned on to notice boards and placed in staff communication folders. But what is worth noting here is RE's comment revealing that, because she did not have a colour printer on the ward, the printed copies of the results were normally only presented in black and white. The colour coding of green and red, representing results that had reached or not reached the Trust benchmarks, were not usually available to staff looking only at the notice boards. It was only on this occasion, when there was an exceptionally high proportion of greens, that RE obtained a coloured copy for staff to see. In addition to herself being 'thrilled to bits' she wanted to communicate the positive results as clearly as possible to ward staff. The example shows that standards implicit in the Trust's scorecards and benchmarking of patient feedback, on which the colour coding of the results were based, were themselves communicated directly to staff; but that an especial effort was made to communicate the results effectively when they were particularly good.

In this example Ward Manager RE showed her own pleasure at the positive results of the patient survey at Hillside Hospital. Interview data shows that managers use positive feedback from patients in a complex mix of overlapping ways, to thank and praise staff for their work, to boost morale and strengthen motivation. These different uses shade into one another; managers in interview did not draw strong and clear distinctions between them. Managers used feedback at one level quite simply to thank or praise staff. The cascading of thank you letters to individual members of staff arguably, in the absence of any other explicit motive, has this aim. In the words of Consultant Nurse VN at Northbank Hospitals quoted earlier in this section 'Thank you for all you've done.' Consultant medical staff passed on positive feedback and praise from patients to junior doctors and themselves added their own praise.

"So, in the informal situation they will be passed on; 'Mr Bloggs thought you were excellent. Well done.' " (Consultant Surgeon BS, Hillside Hospital)

In these examples thanks and praise were mixed together. They were part of the way in which managers used positive feedback. The standards of behaviour or professional performance which managers used to assess the quality of services provided by staff were not in these examples necessarily made explicit by the managers; the managers simply transmitted and by implication endorsed the feedback provided by patients.

The publicising and dissemination of positive feedback is used as I have shown to counterbalance negative criticisms and comments about improvements that are needed. Positive feedback is used to praise and thank staff for their good work. Evidence from interviews also shows that positive feedback is used explicitly by senior managers and executive directors to boost the morale of staff.

“People have written in and said you know ‘I’m really pleased that people like this work for the National Health Service, because they’re doing jobs that most of us couldn’t dream of doing.’ And I think that you use that as a means of saying thank you to staff, in particular the groups of staff who are actually directly involved. But you also use it as a means of morale-boosting the whole organisation.” (Executive Director LS, Hillside Hospital)

Executive Director GH at Northbank talking in interview about the ‘Clinical Indicators’ meeting held every Friday for senior clinical staff and managers made a similar point but in a much more specific context.

“And we have – we give patient feedback from patients. Some of that’s about e-mail information we’ve just received from them. Some of it’s about – some of them – my message on a Friday is to try and give good feedback to staff so they can go off feeling good about themselves and not difficult feedback.” (Executive Director GH, Northbank Hospitals)

My observation of one of these Clinical Indicators meetings in August 2011 provided an example of the use of positive feedback in this way. GH started the meeting by summarising clinical and operational measures of performance for the week: patient falls; ulcers and pressure sores; medication errors; hospital acquired infections; breaches of A and E waiting times; operating theatre cancellations. A service manager then gave a presentation about the introduction and development by the Hospital’s maternity services of community-based ultrasound foetal screening in GPs’ surgeries and community health clinics. She presented the results of positive feedback from patients and talked about operational problems: the service is oversubscribed because in her words ‘the women absolutely love it’. This was a case of positive patient feedback about a successful service development being used explicitly by service managers and executive directors as an example of success, to balance the operational pressures and issues and to focus the staff at the end of the week on positive successes. Here as in other examples positive and negative

feedback were used alongside each other; positive feedback was used to improve morale; negative feedback to improve services.

Although thank you letters and other kinds of positive feedback contain implicit information about the criteria and standards of care that are endorsed by managers, this positive feedback is not used formally by managers to set or improve explicit standards of care. As I have shown managers sent thank you letters and compliments to individual members of staff and circulated them more widely in wards and departments; but they did not at the same time use this feedback to make an explicit point to staff about standards. Talking in interview about letters of praise from patients:

Interviewer “And is anything more done with them beyond that?”

WJ “No.”

Interviewer “They’re not used for specifically for sharing or developing good practice kind of things?”

WJ “Not by me, no. Whether they are by *EE* and her team – I think we did try and do something once, when we were setting up the CAG. I think she wanted good things to be shown there. But as a rule not.” (Consultant Surgeon WJ, Northbank Hospitals)

Similarly compliments were used by managers to complement negative feedback and promote discussion about services informally, but were not used to identify and disseminate explicit standards of care.

Interviewer “Anything else happen to the compliments?”

EW “Not formally. Again they’d be discussed where they fit with anything else that we were talking about. So if they fitted with a complaint, I’d raise that. If someone else had a very different experience and they complained, or the complainant was saying this aspect of the service was very good but that wasn’t so good and that’s something that somebody else has said is very good as well. So I try and fit it in with that.”

Interviewer “But they’re not used as a set of specific examples for sharing and spreading good practice kind of thing, for example?”

EW “No, not formally, no.” (Divisional Nurse Manager EW, Hillside Hospital)

Both of these examples suggest there had been some occasional or informal use of compliments and positive feedback from patients to help identify and set standards of care in services, but also that this was not part of accepted or widespread practice in

the Trusts. The interview evidence taken as a whole indicates that praise and compliments were usually used by senior managers to thank and praise staff rather than to set explicit standards of behaviour or service.

The most publicised and most visible use of positive feedback from patients in Trusts comes in the form of Trusts' formal staff commendation schemes. The staff commendation schemes at Hillside and Northbank Hospitals were based on feedback from patients. The Trusts' formal documentation shows that the schemes were intended to identify and reward outstanding and exceptional standards of care. The monthly Care Awards at Northbank Hospitals were:

“... aimed at celebrating those individuals or teams who have made a real difference to the way we work and the care of our patients.”
(Northbank Hospitals *Care Awards Nomination Form*)

Similarly at Hillside Hospital the aim of the staff commendation scheme was:

“To recognise and promote examples of outstanding contributions to patient care or patient services.” (Hillside Hospital *Staff Commendation Nomination Form*)

The criteria used to assess nominations identified different kinds of contributions but did not in themselves say anything more detailed about the standards on which the awards were based. The criteria at Hillside Hospital for example included: effort and dedication over and above the normal call of duty in the interests of patient care or service; the development and successful application of new or improved methods of patient care or service; and exemplary attitude to work which inspires others. The awards recognised exceptional effort by and attitudes of staff; they also recognised successful innovations in care. Within this framework it was up to the judges to decide what was exceptional and what was successful.

The notion of 'exceptional' standards achievements clearly depends on what is accepted as normal for staff, what is expected as part of their everyday duties. Interview data showed that managers' expectations might differ from patients' expectations.

“And there will be, there is a panel that looks at the nominations and makes decisions on which ones are going forward, so there is a standard, and the bar is quite high because very often you'll find that a patient says some very complimentary things about a member of staff, but when you read it, this is what we expect in the job.”
(Executive Director AT, Hillside Hospital)

Similarly managers might have different expectations of different groups of staff.

“So it’s part, I think the ones that find it hardest to receive a reward very often are the consultants, because what we expect of our senior medical and senior clinical staff is really quite a high bar. So what the patients are receiving is the day job, it’s got to really be above and beyond to be recognised for an award.” (Executive Director AT, Hillside Hospital)

Senior managers appeared from these interview data to have a set of criteria that they used to assess the positive feedback from patients. They had standards that they applied in deciding which members of staff should receive the award. But these standards were not explicit in the formal documentation of the commendation schemes themselves.

Key words in the nomination forms about the aims of the schemes were ‘recognise’, ‘celebrate’ and ‘promote’ the contributions of staff to the care of patients. The form of the awards decision-making and ceremonies in themselves recognised and celebrate the achievements. Awards were made for outstanding contributions to the provision of clinical or non-clinical services for patients, ranging (in examples observed as part of fieldwork in 2011) from multi-disciplinary team work in the diagnosis and treatment of complex life-threatening conditions, through exceptional care of recently bereaved relatives, to the provision of special menus and meals for patients to celebrate a royal wedding. Awards were made immediately before meetings of boards of directors; they consist of a certificate and cheque. They were well publicised through staff newsletters and in the Trusts’ intranets. Staff were said by managers in interview to be gratified to be nominated for an award; they appeared from my observation of award ceremonies to be delighted to receive one. In this way the commendation schemes did directly use feedback from patients to identify and celebrate the achievements of staff. They promoted the contributions of staff through publicity within the Trust, but did not use this positive feedback as the basis for the explicit identification and promulgation of high standards of care. The positive feedback on which the awards were based was used not in the training of staff or to set explicit standards of service provision, but as an example of good practice and to thank and reward staff for their exceptional contributions to the quality of services.

5.5 Improving Clinical Services: Staff Motivation and Management in Neurosciences at Hillside Hospital

In the earlier sections of this chapter I have shown that managers use patients’ subjective experience of patients and positive feedback from patients to motivate staff

and support them in the way they provide services for patients. Managers also use complaints and comments from patients in the training and management of staff to help improve the quality of services. This section examines the ways in these different kinds of feedback were used to motivate and manage staff in one particular setting, the neuroscience service at Hillside Hospital. I selected the neuroscience service at Hillside Hospital as an example for detailed study because in early interviews for this study the Trust's corporate directors and managers said that patients' complaints and surveys had led to substantial initiatives, directly supported by the Trust's executive directors, to improve the quality of care in the neuroscience wards.

My attention was drawn by the first managers I interviewed at Hillside Hospital to the use of patient feedback in the management of the neuroscience services. In this section I draw on data from interviews with these and other managers and on detailed analysis documentary data in Performance Reports and Patient Experience Reports about the neuroscience services. The Performance Reports and Patient Experience Reports were documents made public in the papers of meetings of the Board of Directors; they were also used in the Trust's internal performance review meetings between executive directors and divisional and service managers. I also draw supplementary data about the service from my observation of one of these neurosciences performance review meetings, held in November 2011.

The quality of clinical care in neurosciences at Hillside Hospital was in 2009 considered by executive directors and other senior managers in the Trust to be unsatisfactory and at times unsafe. The focus was on the quality of the service generally, including issues of patient experience and patient feedback.

"I came here in January 2010, so I've been here a year and a half. But when I looked at the complaints, I looked at the staffing levels, looked at the skill mix, looked at the attitude etc., there was a lot of work that needed to be done. So there were issues and trends that were similar about communication or lack of it, about abrupt attitude, about the not caring, things like that. And having been told that this was possibly a problem for a few years." (Divisional Nurse Manager IH, Hillside Hospital)

A substantial example of inadequate and unsafe services was given in interview by consultant physician FM and consultant surgeon BS of a patient who was transferred from another hospital and admitted to one of the wards at 7 o'clock on a Saturday evening in 2009. The patient was admitted by the nursing staff but was not clerked in by the junior medical staff. He was found dead at half past six the following morning,

unseen by junior medical staff and with insufficient observations done by the nursing staff. The coroner's inquest in May 2011 found that negligence by the Hospital had contributed to the death of the patient. The only reason, according to FM, that the Hospital emerged without damning criticism at the coroner's inquest in 2011 was that they were open at the coroner's court about the previous quality of care and provided detailed information about the plans they had put in place and the actions they had taken since the death to improve the service. The significance of the coroner's inquest at the time I was interviewing managers and what was said in interview about executive directors' concerns about the safety of the service together suggest that the primary reason for the involvement of the Trust's executives in the service was not patient feedback on its own but clinical quality and the safety of services more generally.

Complaints and comments by patients often provide the most detailed information about patients' perceptions of care and the way in which services are provided. Individual complaints may identify a whole series of issues to do with staff behaviour, the way they provide treatment and care and the delivery of services more generally. Divisional Nurse Manager IH at Hillside Hospital gave an example (which I examined briefly in Section 5.2) of a complaint from a patient with a meningioma (a tumour of the membranes that cover the brain) and his wife. They complained about the lack of effective care for patients who were incontinent, the lack on the ward of information for patients and their relatives about meningiomas and their consequences, and the failure of the staff to answer questions and talk to the patient's wife when she tried to raise concerns about the quality of care. Senior medical and nursing staff had two very difficult meetings about the complaint with the patient and his wife, where they eventually were able to discuss in detail all the issues that had been raised. The wife subsequently came to another meeting with the nursing staff on the ward, and talked about the care that had been provided and her feelings about it; she asked to be taken round the ward to see if the quality of care had improved since her husband had been on the ward.

As a result of the complaints and concerns about safety, substantial changes were made in 2010 to the medical and nurse staffing of the neuroscience wards. In neurology, consultant medical staffing arrangements were changed so that, instead of 30 consultants with part-time contracts at Hillside Hospital taking it in turns to be on call to the wards, a core team of eight consultants were responsible for all the in-patient care; all 30 consultants provided out-patient services at hospitals in the region. According to consultant physician FM in interview, the introduction of these changes

had been very difficult and had caused a lot of resentment among the staff involved; but it had benefited the in-patient service. Although there was resentment among consultants at peripheral hospitals, who felt that it was now difficult to access the in-patient service for their patients, the in-patient team had become more cohesive. Before the changes the nursing staff on the ward did not know each of the consultants properly; afterwards they knew them much better. Communication and working relationships between consultants and nurses, according to FM, were much better.

The problems on the neurosciences wards also led to changes in nursing and nurse staffing arrangements. Divisional Nurse Manager IH talked in interview about changes that had been put in place since she took up her post at the beginning of 2010. She talked about the previous culture in the neurology ward, an abruptness and lack of care, staff 'doing their own thing'.

"So I've tried to address that in different ways by raising standards, expecting observations to be done, expecting a good quality of care, but also helping the wards by relooking at the staffing levels, looking at the skill mix you've got, if you've got too many juniors and not enough seniors etc.. And we've done a lot of work, particularly on the neurology ward where we've moved a few staff ..." (Divisional Nurse Manager IH, Hillside Hospital)

The management actions mentioned here by IH, moving staff to new posts, were similar to actions in the medical ward for elderly patients I described in Section 5.3 above. Similarly Consultant Physician FM talked in interview about changes in staff and in staff skills that had helped address failings in the quality care for patients with advanced motor neurone disease.

"We've now got a practice development nurse on the ward to upskill the staff. I think the staff were running away from those patients, because they didn't understand them. I can see why that is. I think it's attitude in that you know, we're here to help them, it's not that they're a problem, you know just because they need to go to the loo and they can't move, that's not their fault. So it's attitude. And it comes from the top on the ward." (Consultant Physician FM, Hillside Hospital)

The focus in both these examples was on a combination of interventions with staff to improve the quality of care: moving staff to different jobs; increasing staffing levels and increasing the number of more experienced and senior members of staff on the

wards; making sure that the staff had the skills needed to provide a high quality of care; and being clear about the standards of care that were expected of the staff.

I showed in Section 5.3 that managers use feedback from patients to help improve the quality of services partly by training staff and helping them develop additional skills, and sometimes by moving existing staff to new posts or taking other kinds of management action. This is not to argue that feedback from patients was the direct or only cause of these changes, but the evidence from the interviews with IH and other managers indicates that it was one of the influences that helped set the context and contributed to the ways in which executives and senior managers managed staff and introduced changes in the delivery of services. The more detailed evidence from interviews about the neuroscience service fleshes out this analysis.

“So the complaints certainly were a strong lever to alert me and the organisation to the fact that something wasn’t quite right in that area. And we’ve undergone a process of performance managing every member of staff. Some people have been dismissed, people have improved, and there were some other things in that. So the complaints from patients were certainly a big trigger for making that happen.” (Divisional Manager GC, Hillside Hospital)

Although no details were provided in interview about the number of staff dismissed, the reasons for their dismissal, or the negative sanctions that might have been imposed through performance management, piecing together the evidence from different interviews shows that the changes in senior nurse leadership in the three neuroscience wards in the Hospital since between 2009 and 2011 were substantial. They included a new divisional nurse manager, two new ward managers, new practice development nurses, and new senior staff nurses. The effects of all these changes and interventions taken together were believed to have had a substantial effect on the attitudes of staff and the way in which they provided services. Ward Manager BM summarised in interview in September 2011 the changes in the nursing staff on her ward: She said that she had been appointed in October 2009 and had found the ward ‘in a bit of a state’:

“I think, to me now, the nurses that I’ve got here now, are very keen, you know. The nurses that are raring to go, they’ve got a buzz and they want to do good.” (Ward Manager BM, Hillside Hospital)

The basic change for BM was in staff attitude and commitment. The intention of BM and of more senior managers was that the changes in staff and staffing would lead to a better service.

Although there have been significant improvements in the neuroscience service since 2009, evidence from performance reports and interviews with Trust managers showed that there were still problems in the service in 2011. Trust managers acknowledged this in interview.

“We have a, I hate to call it this, but we have a sort of problem ward, which we’re in the process of dealing with and we have a very strong plan. We’ve closed half of it and we’re doing intensive training with staff and we are minimising the use of bank staff and we are recruiting new staff at senior level so we’ve got strong leadership. And one of the reasons that’s all come about is because – previously we’ve had a history of incidents, clinical incidents, and complaints about that area.” (Divisional Manager GC, Hillside Hospital)

GC recognised that there had been problems in the ward and that these problems continue: ‘we have a ... problem ward’. She did not in this extract identify the nature of the problems, but the actions she identified – training staff and recruiting new senior staff – clearly show that senior managers felt that the problems and the solutions related to the skills and work of staff on the ward. Although managers had been aware of and dealing with problems in the wards for at least two years, they said that further improvements were still needed.

Something of the nature of the current problems in the neurosciences wards is revealed by analysis of the monthly performance reports presented in public to the meetings of the Trust’s Board of Directors. The performance reports presented detailed quantitative data and summarised service performance on a Trust-wide basis in relation to clinical effectiveness, safety, patient experience, finance and operational efficiency and staffing measures. They summarised key areas of concern and commented on services in each of the Trust’s divisions. Taking the report from November 2011 as an example, the Trust-wide executive summary identified problems with health care acquired infections and with access to services in the coming winter months, with neurosciences being one of the services of greatest concern in both areas. The divisional summary for neurosciences identified below target performance and further management action in length of stay, discharge planning, repatriation bed days, referral to treatment waiting times, *Clostridium difficile* cases, hand hygiene audits and ‘for the second month running’ all How Are We Doing? targets. The information in this report shows that, in the context of the management of the Trust as a whole, feedback from patients was one, but only one,

factor that contributed to executives' concern about and focus on the quality of service and staffing in the neurosciences wards.

Analysis of the results of the Trust's How Are We Doing? in-patient survey provides background evidence about managers' concerns with the quality of care and staffing in neurosciences. I outlined in Chapter 4.5 that the way in which benchmarks set by Hillside Trust for the monthly How Are We Doing? survey were set by reference to the results of other hospitals in the national in-patient survey results. Examination of the survey results for neurosciences from the November 2011 Patient Experience report, which were summarised in the Performance Report as below target for the second month running, showed that neurosciences achieved the benchmarks for seven of the 28 individual questions in the survey and did not achieve the benchmarks for 21 questions. Overall the neurosciences scored four points below the benchmark of 86. The largest shortfalls were in answers to questions about communication and relationships between staff and patients: 'When you had important questions did you get answers you could understand from doctors?' and '... from nurses?'; 'Were you involved as much as you wanted to be in decisions about your care?'; 'Did you find someone on the hospital staff to talk to about your worries or fears?'. These were all areas in which feedback from patients in the survey indicated that the quality of care provided by clinical staff for patients in the neuroscience services were below the standards set by the Trust. Although senior managers at Hillside did not talk in interview in the summer of 2011 in detail about the How Are We Doing? results for neurosciences in the same detailed way that nurse manager NT at Northbank Hospitals had talked about the use the Ipsos Mori survey and CQUIN results to close wards and train staff (as I showed in Section 5.3), they did have these results available to them and a ward was partly closed for training.

The Trust's executive directors in 2011 oversaw and supported actions to improve the quality of the neurosciences services. The oversight was exercised in part through monthly performance review meetings, focusing on divisional reports on finance, operational measures of performance, safety, patient experience and staffing. Patient experience was reported in the results of the How Are We Doing? survey.

"So we have to go to the meetings with *the Director of Operations* for example, on a monthly basis, and you can see the How Are We Doing? there. So it says care perceptions, patient engagement, environment and you can see we've got greens, we've got better, but as the Head of Nursing, I have to respond to that. And if they're

red, they want to know why. And then I have to say what am I doing about it. ... I think sometimes they will drill down, particularly like on a neurology ward, where *the Director of Operations* has been brilliant in helping me with sort of a cultural change and what we're doing to turn this ward round." (Divisional Nursing Manager IH, Hillside Hospital)

IH said here that feedback from patients, in the form of the Trust's regular How Are We Doing? survey was used regularly and routinely by the Trust's directors through performance review meetings to help monitor the quality of services. For IH as for other managers the standards of success were the achievement of Trust-wide benchmarks; success was shown as green, failure to achieve the benchmark was red.

My observation of a performance review meeting between the Trust's executive directors and the divisional managers responsible for neurosciences in November 2011 provided some evidence about the priority given to these staffing and service quality issues in neuroscience. As I have shown above the division's How Are We Doing? scores were below the benchmark for the majority of questions about the interaction and relationships between staff and patients for the second month running and had been highlighted as a problem area in the Trust's corporate performance report. The Trust's Director of Operations said at the start of the performance review meeting in November that the meeting would concentrate on finance, 'plus any other burning issues'. The Divisional Manager introduced the discussion of neurosciences by saying that the services were projecting a £2 million overspend, that quality had dropped off and complaints were up, and that there were empty beds in the service because of staffing difficulties. Discussion in the meeting focused on finance and the Division's cost improvement programme, nurse staffing and recruitment, prescribing by consultants, and operating theatre turn round times, productivity and waiting lists and times. During the discussion, the Director of Operations gave instructions about neurosciences to the Divisional Manager: do not fill admin and clerical staff vacancies; do not use agency nursing staff; proceed quickly with plans to recruit nurses from neighbouring trusts; implement plans to improve theatre turn round times by January; and deliver the Division's cost improvement programme. The results of patient feedback, as recorded in the How Are We Doing? survey scores, were not the focus of management attention or action in the meeting. Although the discussion in the meeting was set in the context of patient feedback about the quality of services, and although they addressed staffing and performance issues that would potentially improve the quality of services for patients, the actions

were actually framed in terms of cost improvement, operational efficiency and staffing measures rather than patient experience and quality improvement.

Despite the other priorities and pressures in the service, managers said in interview that there had since 2009 been substantial improvements in the neuroscience service. The trend in How Are We Doing? scores was slowly upwards rather than downwards. The number of complaints was falling.

“I’ve only been in post a year and a half, but I can say, ‘OK in 2009, we had 89 complaints, it’s gone down to 62 in ’10, we’re at 13 now and we’re half way through 2011.’ So that’s good.” (Divisional Nurse Manager IH, Hillside Hospital)

For IH the reduction in the number of complaints was itself good. She said in interview that in meetings with staff she talked about improvements and things that were going well alongside things that needed to be improved further. For her, the positive messages reinforced positive behaviour: managers and staff responded positively to positive feedback and praise.

Despite the difficulties and failure to achieve benchmarks in the neuroscience service as a whole, evidence in interviews suggests that positive feedback and evidence of improvement have a positive effect on staff and managers. Interviewees said that the How Are We Doing? survey results were discussed each month at: the ward sisters’ meeting; at the clinical management group (involving the clinical director for neurosciences, the lead consultants for each specialty, nurses and therapists and general managers) which had responsibility for the overall management, including staffing and finance as well as service provision and quality; and at the clinical governance group which focused more specifically on quality, patient experience and safety. Nobody in interview questioned the underlying value and validity of the results. General managers and ward managers accepted the benchmarks and information contained in the scorecards.

“Basically I look forward to my *How Are We Doing* scores, because I don’t like to see the reds. I like to see green. Greens mean we’re on the right track, you know, red means not so good, we need a lot of improvement. So every month I look forward to looking at it and to see exactly where we are going wrong and pick up on these points. We’ve, there was one month that we did very, very badly, very badly and it was like a shock.” (Ward Manager BM, Hillside Hospital)

The evidence from this and other interviews is that managers and other staff in neurosciences accepted the validity of the patient survey results and the ways in which they were presented. They accepted the Trust-wide benchmarks and targets contained in the reports. They accepted the red, amber and green ratings that compared actual performance with targets; they used the colour coding directly to help identify needs for improvement. They shared the results with ward staff and used them to try to improve the quality of care they provided for patients.

5.6 Summary

In this chapter I have examined how different kinds of feedback from patients are used in different ways to influence staff in the management and provision of services. Patient feedback is used not only directly in the training and management of staff to help improve the quality of services but also to motivate staff and to thank and reward them for their hard work and contributions to the quality of care.

In Section 5.2 I showed that feedback about patients' subjective experience, the stress and distress experienced by patients and their relatives while using services, is used by managers to engage with staff and get them to reflect on the ways in which they provide care and services for patients. This engagement with the subjective experience of patients is intended to motivate staff to improve the quality of care. I also reported individual examples of managers saying that feedback used in this way would actually contribute to improvements in the quality of services; but I found little systematic analysis or monitoring by managers of these effects. In Section 5.3 I showed that patient feedback in the form of comments, complaints and answers to survey questions is used in the training and development of staff. Despite the difficulties that may arise for managers, negative feedback from patients is used by managers to address issues and in the line management of staff. But, again, I reported little systematic analysis or monitoring by managers of the effects of the training and other interventions on the quality of services. Section 5.4 showed that positive feedback from patients is used by managers to praise staff and thank them for their hard work and contributions to the quality of care; it is used by doctors and nurses in their professional portfolios. But, despite the general focus in the Trusts on using patient feedback to improve services, positive feedback is not used to set explicit standards of service quality or improvement. I discuss in Section 7.2.3 in Chapter 7 the implications of the apparent gaps between the ways both negative and positive feedback is used to influence and manage staff and the ways in which it is used to set standards for service improvement.

In Section 5.5 I examined how these different uses of patient feedback play out in the context of one individual clinical service, neurosciences at Hillside Hospital. I showed that feedback from complaints and from patient surveys was used alongside a large amount of additional information from other sources in the training and management of staff to secure improvements in a service that was judged by managers to be unsatisfactory and potentially to be unsafe for patients. Staffing changes were made and the quality of service improved. Positive feedback from patients was used to praise and encourage staff to make further improvements. But at the end of 2011, in the face of severe pressures, the Trust's executive directors gave a lower priority to supporting staff further to improve the quality of service as measured by patient feedback than to addressing financial, operational and staffing issues in the service and the Trust more generally.

Chapter 6 The Use of Patient Feedback: Boards of Directors

6.1 Introduction

In Chapter 2 I argued that the published research literature indicates that the results of patient feedback are sometimes but not always presented to boards of directors of NHS trusts. But there is little evidence in the literature about what decisions boards make as a result of the feedback or what other uses they make of it. In Chapters 4 and 5 I showed that managers in hospitals use different kinds of feedback to help set standards for the quality of services and to manage and motivate the staff who provide those services. My aim in Chapter 6 is to examine what the Boards of Directors at Hillside and Northbank Hospitals say about how they themselves will use feedback from patients and how they actually use it. Do they use feedback to set standards of service and for quality assurance; do they use it to set specific targets for improvement; do they monitor the achievement of standards and targets; or do they use it for other purposes?

I start this chapter by examining what the Boards of Directors at Hillside and Northbank Hospitals said, in response to the Francis Report in 2010 on the Mid Staffordshire NHS Foundation Trust, about how they would use feedback from patients to support the quality of their services and the governance of their Trusts. In Section 6.3 I develop this focus on the formal responsibilities of Boards of Directors by examining the ways in which the Boards use feedback to obtain assurance, through the reports of formal committees and other information and reports, about the quality of the services they provide for patients. In Section 6.4 I examine the ways in which Boards, having developed strategies for the quality of services, themselves actually use feedback in their regular monthly or bi-monthly meetings throughout the year. I end the chapter by analysing a specific example of the use of patient feedback – the improvement of out-patient services at Northbank Hospital – that illustrates and deepens the analysis of themes from the earlier sections.

6.2 The 2010 Francis Report, Quality Strategies and the Use of Patient Feedback

In Chapter 1 I set the development of government policy and managerial practice in the NHS in part in the context of the Mid Staffordshire NHS Foundation Trust scandal of the mid 2000s and the associated reports by Robert Francis in 2010 and 2013. These reports were severely critical of the failures of the Board of Directors

of the Mid Staffordshire Trust to listen to complaints from patients and relatives and to assure the quality of care in Stafford Hospital. The public and government response to the scandal established much of the context in 2010 in which the boards of all NHS trusts were asked to review their standards, governance and performance in the light of the 2010 Francis Report. My purpose in this section is to examine how the Boards of Directors at Hillside and Northbank Hospitals reviewed and developed in 2010 and 2011 their governance arrangements leading to the strategies and procedures that they put in place for collecting and using feedback from patients. Did the Boards' reviews lead to new ways of using feedback to assure the quality of services; did they lead to more explicit and rigorous standards of improvement?

In this section I draw on three sets of data. The recommendations of the 2010 Francis Report and the Department of Health's response to it set specific tasks for Boards of Directors of NHS Trusts and NHS Foundation Trusts. The public Board papers and minutes in 2010, 2011 and 2012 at Hillside and Northbank Hospital provide detailed accounts of what the two Boards said they would do with feedback from patients and what within this time frame they actually did. My observation of Board meetings in 2011 and some interview data provide supplementary data that provide a check on the information obtained from the public documents and provide additional detail.

Although the 2010 Francis Report talked at times about feedback, this related more frequently to the lack of feedback given by managers to staff who had reported incidents or raised concerns than to feedback to the Stafford Hospital by patients or relatives. The Report said that there had been many complaints at the Hospital, many of them about basic nursing care including for example continence, bladder and bowel care, safety, personal hygiene, nutrition and hydration, and pressure area care. But complaints also related to record keeping, diagnosis and treatment and discharge management. Recommendation 6 of the Report said that the Mid Staffordshire Board should review the Trust's arrangements for the management of complaints and incident reporting in the light of the findings of this Report and ensure among other things that staff are engaged in the process from the investigation of a complaint or an incident to the implementation of any lessons to be learned and that it minimises the risk of deficiencies exposed by the problems recurring (2010 Francis Report page 27). The recommendation said in summary that the Board of Directors should ensure that it had systems in place whereby staff learnt from complaints and risks of recurrence were minimised. The Chief Executive of the NHS wrote in February 2010 to all Chairs of NHS organisations saying that the Government had accepted the

recommendations of the Francis Report. He asked all boards to read the Report and review their standards, governance and performance in the light of it.

“My expectation is that every NHS board reads the report in full, but also actively considers the implications for the way that you do your business; how you as a board assure yourselves and the community that you serve of the quality and safety of the services you provide and commission.” (Chief Executive Letter to NHS Chairs 24th February 2010)

The letter thus asked Boards of Directors to review the substance of their standards and actual performance in the quality of care they provided for patients. It also asked them to review the organisational governance arrangements through which they assured the quality of care. In this section I will examine how the Boards of Directors used feedback from patients to generate information about the quality of services; in the next section I will focus more closely on the governance arrangements which the Boards put in place for assurance.

In response to the Francis Report, the Board of Directors at Hillside Hospital considered a report in March 2010 that focused on strengthening the governance and assurance processes at Hillside. Much of the emphasis in the Next Steps section of the Hillside report was on what the Board of Directors itself would do. The Board agenda would be reviewed to ensure systematic approach to quality assurance. There would be greater clarity about and focus on quality and safety at all levels of the Trust. And, in particular,

“Detailed monthly Patient Experience Report including HRWD, complaints and PALS information should form a regular item at each Board of Directors” (Quality Focus Report to Board of Directors, Hillside Hospital March 2010)

Although Executive Director LS (as I shall show in Section 6.4) in interview claimed credit for introducing the reporting of patient feedback to the Board, the evidence here shows that this decision was taken quite clearly in the context of the Trust’s response to the Francis Report. The Patient Experience Report (the contents of which I examined in Chapter 4.5) was first presented to the Board in May 2010. Then as subsequently, although it contained summary information about complaints and PALS contacts, the most detailed data related to the answers to the individual How Are We Doing? patient survey questions. Although the March 2010 paper did not say explicitly what the Board would be asked to do or decide with the patient experience data, it did arguably carry some immediate implications. Because the paper itself aimed to

ensure a systematic approach at Board level and throughout the Trust to quality assurance, the implication is that the Board would consider and use the patient experience data – feedback from patients – to help assure the quality and safety of the services for which it was responsible. I will examine the Board's role in quality assurance more closely in Section 6.3.

An immediate part of the response of the Hillside Hospital Trust to the 2010 Francis Report was to strengthen the reporting to the Board of Directors of feedback from patients about their experience of the care they had received. The development of this reporting and of the quality standards incorporated in the reporting was taken forward by directors not in the form of a separate quality strategy but in the context of the Trust's Annual Plan for 2010/11 and the following two years. The Plan said that improving patient-centred care and patient experience was the first priority for the Hospital. This was reinforced by making improved patient experience one of the Trust's three clinical quality priorities. The aim of improving patient experience would be achieved by the implementation of Transformation Programme and service improvement initiatives in 2010/11; key milestones would be reaching the top 20 percent of acute hospitals locally in national patient surveys in 2011/12 and the top 10 percent in 2012/13. The Trust thus set itself, partly in response to the Francis Report, measurable targets based on patient feedback for quality improvement for the coming three years. Although executives did not present to the Board of Directors a detailed strategy for how these targets would be achieved, the Board itself would receive regular and detailed reports on progress (or lack of progress) towards these targets. The focus at Hillside was on the detailed measurement of patient experience and the reporting to the Board of the results of the How Are We Doing? survey of patients.

I will examine in more detail in Section 6.4 the context and content of discussions in 2011 about the Patient Experience Reports by the Board of Directors in 2011. For the moment the point to emphasise is that the Board papers and my observation of Board meetings show that the Board did receive and discuss at every meeting in public from May 2010 onwards reports that summarised complaints and PALS data for the Trust and contained detailed information about the answers to all the How Are We Doing? survey questions. These different kinds of patient feedback were presented to the Board as trends over the previous 12 months for the Trust as a whole and as analyses of the results for each of the Trust's clinical divisions. The HRWD results were compared and colour coded in both the time series and the divisional analyses against the Trust-wide benchmarks established on the basis of

comparison with other local hospitals' scores in the national survey of in-patients. The Board of Directors received this information; the question to be examined later is how they used it.

The Board of Directors at Northbank Hospitals responded differently to the Board at Hillside to the recommendations of the Francis Report. The Board at Northbank focused not on strengthening the reporting of existing measures of patient feedback and patient experience, but on a more fundamental review of patient and public involvement in the Trust that then itself, along with concerns about out-patient services that I examine in Section 6.5, led to the development of a new Quality Strategy for the Trust. A report to the Board in April 2010 focused mainly on the quality of nursing care and on nursing leadership. It asked if the Board was satisfied with the standards, performance and governance arrangements to monitor standards of care in the Trust and asked the Board to agree a mechanism for listening to patients' stories. The minutes of the meeting said that the Board 'noted' the actions being taken forward on the recommendations of the Francis Report; they did not say whether the Board was or was not satisfied with the standards of care in the Trust. The minutes also said that the Board had commissioned a report on listening to patients' stories.

The development of the Trust's strategies for listening to patients' stories, collecting other kinds of feedback from patients, and for patient experience and the quality of services more generally, developed in three main stages between April 2010 and September 2011. In July 2010 the Board considered a report that examined in detail the large number of mechanisms in the Trust for 'involving and listening to patients'. The paper asked the Board to decide which mechanisms it would like to adopt; the minutes of the meeting said that the Board supported the proposal for their greater involvement in receiving patient feedback and asked the Chief Nurse to prepare an action plan. In March 2011, after detailed and difficult discussions at the Board about the quality of out-patient services (which I examine in Section 6.5) the Board considered a 'Patient Experience Report' which contained a wider ranging and more detailed analysis of patients' views about services than any other reports presented to meetings in public of the Board in 2010 or 2011. The report concluded that the majority of patients were satisfied with the care they received but that there were some areas (including the start of the patient pathway, consistency of clinical care through 24 hours a day, and communication and engagement between staff and patients) that needed further improvement. As a result a further report 'Quality Strategy 2011 – 2013' was presented to the Board in September 2011; this report

claimed itself to be based on feedback from patients, proposed eight 'patient experience priorities' for the Trust, and identified the mechanisms through which patient feedback about these priorities would be reported to the Board of Directors in the future. Although the minutes of the meeting did not say that the Board made any decisions about this paper, my observation notes from the meeting show that at the end of the long discussion about the paper, the Chair 'warmly welcomed' the strategy and that it was 'a good step forward'. The strategy thus served as the stepping off point for the Board's subsequent monitoring of patient feedback and actions the quality of services.

Following the September 2011 meeting the Board of Directors received no papers and held no discussions in public meetings about how the eight patient experience priorities identified in the strategy would be measured or reported to the Board. There is no evidence from the minutes of the meetings of the Trust's Assurance and Risk Committee held in August and December 2011 that the Committee itself discussed these issues. The first meeting of the Trust's new Quality Committee (which replaced the ARC in January 2012) considered a new style Patient Safety and Experience Report which replaced the previous Quality and Safety Reports. The Patient Safety and Experience Report for the period December 2011 to February 2012 was presented to the meeting in public of the Board of Directors in April 2012. The 'One Stop Summary' at the beginning of the Report reported performance in four areas: key Quality Strategy indicators, including for example the number of deaths, pressure ulcers, and overall patient satisfaction scores; seven Quality Strategy Patient Experience Standards; Monitor Compliance Framework Risk Assessment, including for example health care acquired infections and cancer treatment waiting times; and CQUIN targets, including for example dementia screening, end of life care and patient experience in national and local surveys. The report said that the Patient Experience Standards were monitored via questions included in the Trust's near-time electronic patient survey system. The questions themselves were based on the national survey of in-patients. The scores derived from the answers to all the Patient Experience Standards questions were shown in the report in a green, amber or red colour coded format, the colour coding reflecting the relationship between the actual score and the target score for each standard. The target for each of the six in-patient Patient Experience Standards was set at 85 percent; scores for the two out-patient Standards would be reported later. Neither the Patient Safety and Experience Report itself or other reports to the Board of Directors meeting in public in 2011 or 2012 explained how the scores for each of the in-patient

Patient Experience Standards were calculated or how the 85 percent targets were set. The targets based on patient feedback were incorporated in reports that gave greater emphasis to a much wider set of clinical and operational measures; the rationale for the specific patient experience and patient feedback targets was not made public.

In addition to identifying quality and safety principles and priorities, the Quality Strategy 2011 to 2013 prepared in September 2011 outlined ways in which the Trust would in future obtain feedback from patients. In addition to current mechanisms of surveys, workshops and specialist groups, comments and complaints, feedback would in future also be collected through near-real-time electronic data collection, mystery shopper programmes and a new ward accreditation scheme. The report did not identify explicitly how progress in the eight priority areas would be assessed or measured. Nor did it say how progress with these eight priorities or with the strategy more generally would be reported to the Board of Directors. Instead it said that ‘ we will triangulate and streamline patients’ views into measurable performance metrics.’ The Trust Management Executive and Board of Directors could expect ‘patient satisfaction performance data’ to be presented in the quarterly Quality Report to the Board’s Quality Committee and at the beginning of each TME and Board meeting.

Reports to the Board of Directors up to July 2012 show that the Board received a variety of information based on feedback from patients, but the minutes of meetings suggest that there was very little discussion about this feedback and the Board itself did not at this time base on the feedback formal decisions about further actions to be taken. In 2012 the Board moved from bi-monthly to quarterly meetings in public. None of the 2012 Board meetings began in the way that the Quality Strategy had proposed with a presentation of patient satisfaction performance data. The results of patient feedback were presented to the meetings in public of the Board in April, July and October 2012 in the quarterly Patient Safety and Experience Reports. The minutes of the Assurance and Risk Committee meeting in November 2011 were included in the publicly available papers of the Board of Directors in January 2012; the minutes of the Quality Committee meeting in October 2012 were made public with the papers of the Board meeting in January 2013. The minutes of the Quality Committee meetings in January and April 2012 were included in the papers for the meetings in private of the Board in Committee in March and June 2012, and were thus not themselves made publicly available. Analysis of the publicly available minutes of the Quality Committee and the Board itself from 2012 reveals no evidence of discussions at or decisions by the Committee or Board specifically about the Patient

Experience Standards based on feedback from patients. The minutes of the meeting in public in July 2012 of the Board of Directors show that there was discussion about the 18 week referral to treatment time target, cancer waiting times, clinical coding and the handling of complaints. The only mention in the minutes about the results of patient feedback related to the operation of out-patient clinics that had recently transferred to different accommodation and the difficulties experienced by some elderly patients in using the electronic check-in system. Apart from this there was no record in the minutes of discussion about the results of the near-time patient feedback or other kinds of feedback or about the Quality Strategy Patient Experience Standards.

Despite the apparent lack of specific reference in the minutes of 2012 meetings to feedback from patients or the Patient Experience Standards in the Quality Strategy, the Board of Directors appeared to draw assurance from the Quality Committee and the Patient Safety and Experience Reports about the quality of services.

“The Board welcomed the Committee’s report, noting the overall position on quality remained strong. The significant rubbing points on the 18 week target for example and other action points noted – should be kept under close review by the Committee.” (Minutes of the meeting held in July 2012 of the Board of Directors, Northbank Hospitals)

The ‘other action points’ included A and E performance, cancer waiting times and the handling of complaints, but nothing about the Patient Experience Standards. The Board itself received assurance from the work of the Quality Committee and from the wide range of information contained in the Patient Safety and Experience Report. It interpreted this information as saying that the Trust’s position on quality ‘remained strong.’ But, as the evidence above suggests, the Board itself did not at any time in 2011 or 2012 receive the full set of information based on patients’ stories, complaints, surveys or other kinds of patient feedback that it had said it wanted to receive and that would have enabled it to monitor directly for itself the impact of its Strategy on the quality of services. It is not clear from the evidence I have presented so far how the Board at Northbank Hospitals obtained assurance from patient feedback about the quality of services.

6.3 Quality Assurance: Boards and Committees

I have shown in the previous section that one of the issues arising from the Francis Report was the role of boards of directors of NHS foundation trusts in assuring the quality of the services for which they are responsible. Legislation and government policy require NHS foundation trusts to collect and use feedback from patients to assess the quality of services. Boards of directors have the authority to delegate some of their functions to formal committees established by the board. My purpose of this section is to examine the ways in which the Boards of Directors at Hillside and Northbank Hospitals themselves used feedback from patients, or drew on reports from Committees of the Board, to seek and obtain assurance about the quality of services they provided for patients. Did the Boards themselves set and monitor explicit criteria and standards of service quality; or did they rely on others to do this on their behalf?

In this section I draw on documentary evidence in the form of legislation and guidance issued by regulatory bodies and then, in more detail on the agendas, Board papers, minutes of meetings and other documents at Hillside and Northbank Hospitals. This documentary evidence is supplemented by my own observation of meetings of the Boards of Directors of the two Trusts and by data from interviews with directors and governors of the Trusts.

Boards of directors of NHS foundation trusts exercise, under the terms of the National Health Service Act 2006, the powers of the trust. NHS foundation trusts are themselves public benefit corporations that are authorised to provide goods and services for the purposes of the Health Service in England. Boards of directors therefore carry full responsibility for all aspects of the services that they are authorised to provide. Legislation, government policy and the requirements of regulatory bodies in various ways, directly or indirectly, expect boards of directors of NHS foundation trusts within their broad responsibilities themselves to use feedback from patients to assess, assure and improve the quality of services for patients. I have shown in Chapter 4.3 that The Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 require 'the registered person' (in this case the NHS Foundation Trust) to use the complaints, comments and views of service users to come to an informed view about the standard of care and treatment provided. The registered person must also have a system for responding to complaints that reduces the risks of unsafe or inappropriate care or treatment.

Similarly, but in more detail, Monitor's assessment of the continuing viability of foundation trusts includes criteria relating to their engagement with patients, service

users and commissioners, and to being 'well-governed' from both a financial and quality perspective (Monitor 2011). Trust boards are required to make self-certification statements stating that they are in compliance with the Care Quality Commission's registration requirements and that they have effective arrangements for monitoring and improving the quality of their services. In making these statements boards are expected to have regard to Monitor's Quality Governance Framework. The Quality Governance Framework (Monitor 2010, 2011) is set in the context of improving the quality of services; trusts are expected to engage actively with patients and other key stakeholders on quality, for example: patient feedback is actively solicited, made easy to give and based on validated tools; all patient feedback is reviewed on an on-going basis, with summary reports reviewed regularly and intelligently by the board; the board regularly reviews and interrogates complaints and serious untoward incident data; and the board uses a range of approaches to 'bring patients into the board room' (e.g. face-to-face discussions, video diaries, ward rounds, patient shadowing). Although the emphasis in Monitor's framework is (like Department of Health policy generally) very much on the collection rather than the use of feedback from patients, boards of directors are expected to review feedback and use it to improve the quality of services.

Boards of directors of NHS foundation trusts have responsibility for all aspects of the services they are authorised to provide. This responsibility includes, in the words of the Northbank Hospitals Annual Report for 2010/11, setting the Trust's strategic directions, monitoring the Trust's performance, providing effective financial stewardship, ensuring the Trust provides high quality, effective and patient focused services, and ensuring high standards of governance and conduct. The responsibility of boards of directors for the quality and governance of services means that they are also responsible for patient experience and for the use of feedback from patients to assure and improve the quality of services. Boards have the authority to reserve certain matters to themselves or to delegate them to committees or to their chief executive or other managers. The Boards of Directors of Hillside and Northbank Hospitals delegated responsibility for aspects of the quality of services to committees, the Quality and Governance Committee at Hillside Hospital and the Assurance and Risk Committee at Northbank Hospitals. The purpose of the Quality and Governance Committee at Hillside is:

"To provide assurance to the Board on all aspects of quality and governance. To review performance against the three domains of quality, Patient Safety, Patient Experience, Patient Outcomes, and

organisational safety, information governance, compliance with a range of external regulatory bodies.” (Hillside Hospital, Annual Report of the Governance Committee and Quality and Governance Committee April 2010 to March 2011, page 10)

The full range of the responsibilities of the Assurance and Risk Committee at Northbank Hospitals is indicated by the agenda of the Committee meeting in December 2011: information assurance; care of the elderly; risk management quarterly report; infection prevention and control quarterly report; Care Quality Commission Risk Profile; management of risk annual report; complaints and litigation quarterly report, complaints management process, Board assurance process, Trust-wide risk register, and management of retained tissue. The delegation of responsibilities for reviewing performance and providing assurance on all aspects of quality means that these Committees, at Hillside and at Northbank, are responsible within a much broader set of responsibilities for advising the Boards about the ways in which feedback from patients is used to support and improve the quality of services.

Boards of directors delegate responsibilities not only to committees of the board but also to the chief executive of the trust and to other individual managers. Chief executives are responsible for the overall organisation, management and staffing of a trust. Formal committees of the board of directors (themselves chaired by the Chair of the Trust or another non-executive director) are supported by sub-committees or working groups chaired or led by executive directors or other senior managers of the Trust. Following the publication of the Francis Report, Hillside and Northbank Trusts both reviewed the structure and responsibilities of their Board committees and sub-committees and introduced changes in 2010 and 2011. The Hillside Hospital Quality Account for 2010/11 said that the Quality and Governance Committee at the Hospital was to be supported by four sub-committees: the Patient Outcomes Committee; the Patient Experience Committee; the Patient Safety Committee; and the Organisational Safety Committee. The Northbank Hospitals documents examined for this study did not identify sub-committees of Board committees. The Annual Report for 2010/11 identified the responsibilities of the Trust Management Executive, including for example managing risk, developing strategy, and developing and monitoring the implementation of plans to improve the efficiency, effectiveness and quality of the Trust’s services. The Management Executive would be supported by sub-committees including a Clinical Governance and Risk Management Sub-committee. The management arrangements in both Trusts in these slightly different ways provided organisational structures through which

information about patient experience and the quality of services, and hence about patient feedback, would potentially be reviewed and reported to the Boards of Directors.

Managers in interview identified differing views about the role and operation of Committees in providing advice and support for the Board in the use of patient feedback. At Northbank Hospitals, the main principles of the structure were clear, but managers had different views about how it actually worked. The Assurance and Risk Committee (ARC) was a formal committee of the Board, chaired by a Non-executive Director, meeting quarterly. The Committee was supported by the Clinical Governance and Risk Management Committee that was chaired by the Medical Director. The Clinical Governance Committee received a Reactive Risk Report that covered legal cases as well as complaints, compliments and comments. The ARC considered the Quarterly Quality and Patient Safety Report which was also presented to meetings in public of the Board of Directors. The Quality and Patient Safety Report was, in the words of Corporate Nurse Manager NT 'the main engine' for the ways in which the Board and Committees received information based on patient feedback. But, for NT's line manager Executive Director GH, the position was different. GH was asked in interview about how all the different kinds of patient feedback were used in the Assurance and Risk Committee. She replied:

"Yes, well I think that's tricky, difficult actually, I think. We've got an Assurance and Risk Committee, which is a formal sub-committee of the Board, chaired by one of our non-execs. And there is a regular quarterly report which gives an overview of complaints, incidents, risk and everything else. But that very much doesn't talk about patient feedback. It relies on me to report on the reports that I send to the Board on explicit stuff around patient experience." (Executive Director GH, Northbank Hospitals)

Although GH said here that the quarterly report contained an overview of information and complaints, risks and 'everything else', she also said that it does not talk about patient feedback. She herself talked to the Board about 'patient experience'. In this, to judge from some of the examples focusing on individual patients' stories that GH gave elsewhere in her interview, GH appeared to be drawing a distinction between the quantitative aspects of patient feedback, the kinds of information that could be summarised numerically, and the subjective aspects of patients' experience. She was by implication saying that the Assurance and Risk Committee did not effectively

consider the nature of patients' experience and that it could not therefore provide assurance or advice to the Board about this issue.

Other directors took a different view of the relationship between Committee and the Board. Executive Director WB at Northbank Hospitals appeared to take the view that the Assurance and Risk Committee (ARC) did provide the Board with the assurance the Board needed about issues raised in feedback from patients.

"The Trust however internally is very clearly also looking at patient feedback. And we have an Assurance and Risk Committee. And it's that Committee that tends to look at the broader issues of patterns of patients' complaints, patterns of patients' surveys, responsiveness to issues that are raised by patients. And you're right that it tends to stick there rather than something which gets addressed at the Board. Now I'm afraid I'm a bit of a cynic about organisations. I mean I think you need to keep governance in the round and you know I don't think it necessarily has to be the Board that looks at these issues as long as the Board is assured that those issues are being looked at." (Executive Director WB, Northbank Hospitals)

In this WB agreed with GH that the ARC took a broad view of complaints and surveys; the difference between them lay in his view that this in itself provided the assurance the Board needed about these issues. The Board did not need additional information or to know in detail the results of the feedback or what the Committee had been discussing; it needed only to be assured that the Committee was looking at the issues. The difference of view between these two Executive Directors then raises the question of exactly how Boards obtain assurance from Committees about the issues raised in patient feedback and the actions that are being taken to maintain or improve the quality of services.

The Committee structure of the Board at Hillside Hospital was reviewed in 2010, with new arrangements being put in place in 2010 and 2011. A Quality and Governance Committee came into being in October 2010 chaired by a Non-executive Director and meeting every two months to provide assurance to the Board on all aspects of quality and governance. The Committee was itself supported by three other committees, chaired by Executive Directors, relating to Patient Safety, Patient Outcomes, and Patient Experience. The Patient Experience Committee was being established in the summer of 2011 at the time of interviews for the present study. Managers in interview said that it would be more focused on actions and action

planning than had its predecessor Patient Carer Experience Group, which had become, according to Corporate Manager VF, 'a bit of an information dump'. The Quality and Governance Committee itself was designed, according to Executive Director LS, to give Directors more time to have proper discussions about quality issues, rather than the Board meetings becoming 'tick box' exercises. This approach, like that of Executive Director WB at Northbank Hospitals, raises the question of how Boards themselves formally get assurance from the more detailed discussions in Committee. It also raised the question, if the detailed discussion takes place in Committee, what the Boards themselves actually discuss and decide in relation to feedback from patients.

Reports from Committees to meetings in public of the Boards of Directors at Hillside and Northbank Hospitals in 2011 provide little evidence of the direct use of patient feedback in providing assurance to Boards about the quality of services. Although the Annual Report of the Governance and Quality and Governance Committees at Hillside Hospital for 2010/11 said that minutes of the quarterly meetings of the Committee were presented to the Board, I have found no documentary evidence that minutes or reports from the Quality and Governance Committee were actually presented to meetings in public of the Board during 2011. The only report of this kind was the Annual Report of the Committee in April. This Annual Report focused on the documents and procedures that the Committees had reviewed in the previous year, as distinct from specific aspects of the quality of services that might have been the subject of feedback from patients. Unlike Hillside Hospital, minutes of three of the quarterly meetings of the Assurance and Risk Committee at Northbank Hospitals were included in the agendas of the meetings in public of the Board. These minutes referred on each occasion to discussions about the handling of complaints. They referred once (without giving any specific information) to differences between the results of the national survey of in-patients and the results of the Trust's quarterly telephone survey. The only occasion on which the minutes made any explicit statements about the achievement or non-achievement of specific quality standards related to survey questions about the provision of advice about the side effects of medication and to improvement initiatives being taken in the Trust on this issue. The Annual Report of the Quality and Governance Committee at Hillside Hospital and the minutes of the Assurance and Risk Committee at Northbank contained no evidence indicating that any matters discussed at the Committees had not been recorded at least in outline in these documents. This analysis shows that there is an absence of documentary evidence that Committees explicitly used the

information about feedback from patients to provide assurance to the Boards about the quality of services in 2011.

Evidence from my notes of observations of all the Boards of Directors meetings held in public in 2011 paints a similar picture. The focus in my observations was on patient feedback. My observation notes suggest that Boards of Directors are told that Committees examine feedback and identify improvements that are needed; the Boards of Directors do not receive detailed, substantive reports on the feedback that has been examined or on the improvements that are being put in place. The most specific statements were statements by Executive or Corporate Directors about what would happen in the future, as distinct from what did actually happen currently. At Northbank Hospitals the Board was told in September 2011 that the results of the new electronic system of collecting real-time feedback from patients would be reported every quarter to the Trust's Quality Committee. At Hillside Hospital the Board was told also in September that the newly established Patient Experience Committee would look at how best to co-ordinate the results of different kinds of feedback and would then report through the Quality and Governance Committee, which was itself a Committee of the Board. But none of my observation notes of Board meetings in 2011 contain any information showing that the results of feedback were in fact reported by these Committees to either Board.

Taken together these findings suggest that Board Committees make very little explicit use of feedback from patients in providing assurance to Boards of Directors about the quality of services. The findings show that, if Committees do themselves use patient feedback in assessing the quality of services, then the evidence of assurance that they present to the Boards does not explicitly identify this feedback; Boards are presented with the conclusions of the assurance process rather than with summaries of the evidence that led to the conclusions. The lack of detailed evidence to the contrary tends to support the view of Executive Director WB at Northbank Hospitals that Boards of Directors receive assurance that issues raised through patient feedback are being looked at and dealt with by Committees, rather than the Boards themselves directly considering the reports of Committees that identify the issues and the actions that have been taken.

This analysis then raises the question of whether Boards of Directors themselves use patient feedback to help assure the quality of services. Although there is some evidence that feedback from patients is used generally in the Trusts to help monitor and assure the quality of services for patients, there is little direct evidence that the Boards of Directors themselves explicitly use feedback for this

purpose. The indirect evidence comes in the form of interview statements by general managers and governors, especially at Hillside Hospital, about quality assurance. Some managers at Hillside saw feedback as assurance.

“So I think it’s an assurance check to make sure that we are really – I mean there are all sorts of things in this really. I think it is about joining up with adverse incidents and complaints – it’s another way of really being assured, seeking assurance that what’s going out there is safe really. And the patients are being treated with dignity and all the rest of it.” (Divisional Manager PE, Hillside Hospital)

But these managers did not talk explicitly about the Board using feedback as assurance. Similarly Governors of the Hillside Trust saw the presentation of the Patient Experience Report to the Board of Directors as providing assurance for the Governors and by implication for the Board itself. Governors MF and AD both made the point in interview when asked about the use of the survey:

“I find I get assurance from it, really, that’s my general kind of flow. I mean if I go to a directors’ meeting ... you know at the last one I think they had a good 30 minutes plus discussion on issues from those surveys. And so I get assurance that it’s on their agenda, and that they really mean it. It’s not just for show.” (Governor AD, Hillside Hospital)

Although AD did not say exactly how the Board used the survey and did not provide supporting evidence to show that the discussion was ‘not just for show’, he was clear the survey was part of the information used by the Board in its oversight of the services provided by the Trust. My observation of Board meetings, where there was presentation and discussion of How Are We Doing? results at every meeting in 2011, confirms AD’s point. The Board considered and talked about patient feedback at every meeting; but this still leaves open the question about how they actually used it.

Despite the indirect evidence, the question still remains as to whether the Boards of Directors actually sought and obtained assurance about the quality of services from patient feedback. None of Directors or other managers of either Trust explicitly said in interview that the Board of Directors used feedback from patients to assess or assure the quality of services. The most significant evidence about the role of patient feedback in contributing to the assessment of quality or assurance of quality by either Board related to Northbank Hospitals. In Board meetings in March and April 2011 Directors talked about the kinds of information they would need to assure themselves that the quality of out-patient experience was improving; but as I have

showed in Section 6.2, this discussion did not result in the regular reporting to the Board of the detailed information from patient feedback that would potentially have provided the Board with this direct assurance. Soon afterwards Executive Director WB at Northbank talked in interview about the need for assurance, both in relation to out-patient services and the quality of services more generally. In the context of particular problems that elderly patients had experienced in the arrangements for discharge from in-patient care he talked about using feedback from local groups, as well as survey and complaints information, to

“... reassure ourselves that things that were happening elsewhere were not happening here.” (Executive Director WB, Northbank Hospitals)

Here, because of WB's position as an Executive Director of the Trust, it could be argued that 'ourselves' meant the Trust as a whole, or the Management Executive, or the Board of Directors. The evidence here, as at Hillside, only suggests indirectly that the Board of Directors actually might have used patient feedback to assure the quality of services. But the regular written reports to Boards of Directors containing the results of patient feedback did not say that they intended to provide the Boards with assurance; they were presented 'for report' or 'for discussion'. The minutes simply stated that the reports were noted; they said nothing about assurance. The evidence therefore indicates that Boards of Directors may implicitly use feedback to help assure the quality of services, but that they do not themselves explicitly and directly use it for this purpose.

6.4 The Use of Patient Feedback: Discussions and Decisions

In Chapter 4 I examined the ways in which Trusts used the results of surveys and other kinds of feedback from patients to set standards for the quality and delivery of services. In the last two sections of this chapter I have examined how the Boards of Directors at Hillside and Northbank Hospitals responded to the Francis Report by saying that they would use feedback from patients to help assure and improve the quality of services. I have also shown that it is not always clear that Boards have actually used feedback in the ways that they said they would. In this section I examine how the Boards of Directors at Hillside and Northbank Hospitals actually used feedback in carrying out their everyday responsibilities in their Trust. I focus both on the discussions that Boards have about patient feedback and on the decisions they make using that feedback. Do Boards simply talk about feedback from patients, or do they actually use it to improve the quality of services?

In examining the discussions and decisions of Boards of Directors about patient feedback, I draw primarily on data about meetings held in public in 2011. There were 20 such meetings in total, 12 at Hillside Hospital and eight at Northbank. The data about each meeting consist of reports and other papers presented to the Board, my observation of these meetings and the minutes of the meetings. Although the meetings themselves were held in public the papers and discussions also occasionally referred to meetings held in private, providing some information about activities that were not directly observed as part of the research. Additional data are drawn from interviews with managers in the two Trusts, which provide information about the use of feedback by Boards in private meetings and discussions. The main focus of the section however is on discussions held and decisions made in public.

The regular Chief Executive's Reports to the meeting of the Board of Directors provided opportunities for the Chief Executives to inform the Boards about the results of or issues arising from feedback from patients. Chief Executives' Reports were presented to the Boards for information; they contained a variety of material about initiatives or changes in the Trust and about external events of one kind or another. At Northbank Hospitals feedback from patients was mentioned only once in the course of 2011 in the Chief Executive's written reports to the Board. The Report to the April meeting of the Board said that the Care Quality Commission had made an unannounced visit to the Trust: 'Four inspectors spent the day at *St. Dunstan's* observing care, meal times, interviewing patients, relatives and staff and reviewing documentation.' The inspectors were positive; the care they observed was good and they had no major concerns.

"All patients and relatives they interviewed were very complimentary about their care and many stated it was the best hospital they had been in." (Chief Executive's Report to the meeting in April 2011 of the Board of Directors Northbank Hospitals)

My observation notes of the April meeting contain no record of any discussion directly about the feedback from patients. The minutes of the meeting referred to the positive verbal report from the inspectors and the feedback from patients:

"The Board noted the positive feedback from the recent unannounced Care Quality Commission visit and in particular the comments from patients and their relatives. The comments about improving care planning supported work that had already begun." (Minutes of the meeting held in April 2011 of the Board of Directors of Northbank Hospitals)

The Board noted the Chief Executive's Report and the positive information about patient feedback contained within it. The discussion focused on the ways in which the findings of the CQC visit supported initiatives already being taken by the Trust to improve the quality and delivery of services. This evidence, and the lack of any other mention of patient feedback in any of the Chief Executive's Reports in 2011, shows that the Chief Executive's Report at Northbank Hospitals was not a vehicle for raising issues or promoting discussion by the Board about feedback from patients.

The Chief Executive's Reports at Hillside Hospital, unlike Northbank, mentioned feedback from patients at six of the Board meetings in 2011. Much, but not all, of the reporting highlighted positive feedback. Positive feedback from patients through Care Quality Commission visits, local surveys and press reports was reported to the Board. The Reports included each month a summary of media events: an example in the February Report of positive feedback summarised a report in a local newspaper in another part of the country about the care provided for a patient who had had a liver transplant:

"Andy describes the liver team at *Hillside* as 'a well oiled machine' and the care he received as 'unbelievable' ". (Chief Executive's Report to the meeting in February 2011 of the Board of Directors, Hillside Hospital)

Similarly the Chief Executive drew directly on the results of the Trust's How Are We Doing? survey and his own observations in reporting positive feedback to the Board. In the Executive Summaries at the beginning of each Report he made judgements and set the context for more detailed material later.

"I am pleased to be able to report this month on a number of events which demonstrate the Trust's focus and commitment to patient safety and quality of care." (Chief Executive's Report to the meeting in June 2011 of the Board of Directors, Hillside Hospital)

In his verbal report to the June Board meeting the Chief Executive said that he felt 'optimistic': integrated care was progressing well; there had been positive stories about the Trust in national newspapers, and complaints were at their lowest level. He continued to report positive patient feedback in the autumn.

"September is the time of year when we are coming out of a quiet summer and building up to the challenges of winter. ... Nonetheless, we continue to perform well. We are meeting all our access targets, and I think that we are in reasonable shape with regard to our financial performance, which is particularly challenging. We have

had the best series of results in How Are We Doing? ... ” (Chief Executive’s Report to the meeting in September 2011 of the Board of Directors, Hillside Hospital)

In this variety of ways the Chief Executive’s written Reports and his verbal reports to the Board of Directors highlighted positive feedback from patients. The Board in its meetings noted these positive reports.

Although much of the emphasis in the Chief Executive’s Reports at Hillside was on positive feedback, this was not always the case. The Chief Executive also reported to the Board on feedback that was not positive and presented information about the ways in which feedback indicated needs for improvement or supported existing initiatives to improve the quality and delivery of services for patients. In the Media Events section of the Report in January 2011 he said that a local newspaper had picked up a report by the Patient’s Association about a patient in the Trust who had:

“ ... experienced significant failings in the care we provided. The case is now being used as part of our ongoing drive to improve standards across the Trust, and has been reviewed at the Board and the Senior Leaders’ Team.” (Chief Executive’s Report to meeting in January 2011 of the Board of Directors, Hillside Hospital)

As there is no record in the minutes of meetings in public of the Board discussing the Patient’s Association report, this review presumably took place in a private, Part 2, meeting. The issue was brought to the public part of the meeting after the local press coverage. It was presented in the context of a ‘drive’ to improve services.

Concerns about the care of the patient included in the Patient’s Association Report were presented to the Board as part of the Trust’s ‘ongoing drive to improve standards’. The Hillside Chief Executive’s Reports also on other occasions presented feedback from patients as part of the work being done in the Trust to improve services. Three Reports in the second half of 2011 talked about feedback from patients about the cleanliness of wards and bathrooms in the context of the Trust’s private finance initiative contract with the company contracted to provide cleaning services in the Hospital. In June the Chief Executive said that a clean hospital was essential to preventing hospital acquired infections ‘which remain the most significant challenge for the Trust’. In September he reported that an agreement had been reached with the contractor, and gave more information in November:

“As per the newly signed agreement between Medirest and the Trust, any additional payments will be directly linked to patient

perception and satisfaction, as determined by the How Are We Doing survey. We look forward to sustained improvement and patient focussed delivery of these essential services.” (Chief Executive’s Report to meeting in November 2011 of the Board of Directors, Hillside Hospital)

The Director of Finance commented in the meeting that this was the first time, as far as he could find out, that feedback from patients had been used as part of the payment mechanism for PFI contracts in the NHS. By meeting targets based on the How Are We Doing? feedback the contractors would earn income that enabled them to make a profit above their costs in providing the service. In reporting to the Board in this way the Chief Executive demonstrated that feedback from patients could be used not only to monitor and assess specific aspects of the quality of services but also directly to help improve quality. The evidence here shows that the difficulties in the control of infection and cleanliness – the subjects of regulatory monitoring and inspection by Monitor and the CQC respectively – and the innovative contractual use of feedback from patients were both the subject of reports to and discussion by the Board of Directors.

Analysis of regular Performance Reports to the Boards of Directors at Hillside and Northbank Hospitals, and especially discussion by the two Boards about the Reports, suggests a similar pattern, with more attention being paid by the Board at Hillside than the Board at Northbank to feedback from patients as a component of the overall performance of the Trust. I have examined in Chapter 4 the numerical information based on patient feedback that was contained in the Performance Reports. Reports at Hillside contained information drawn from the Trust’s How Are We Doing? survey about CQUIN targets and about patient engagement, the hospital environment and perceptions of care; Performance Reports at Northbank drew on the Trust’s quarterly telephone survey only to report on CQUIN targets. The Executive Summary of the Performance Reports at Hillside Hospital mentioned feedback from patients three times in 2011; the Introduction to the Performance Reports at Northbank did not mention it at all. Observation and minutes of meetings show that patient feedback was discussed by Directors as part of the Performance Report on at least four occasions in 2011 at Hillside but not at all at Northbank. The most substantial discussions at Hillside took place in October and November, at a time when reports to and minutes of the Board meetings show that the Trust was experiencing significant pressures in terms of finance, health care acquired infections and referral to treatment access times. Following the high How Are We Doing? scores

and the low level of complaints in the summer, the HRWD scores were deteriorating. Discussion at the Board of Directors focused on the fact that the HRWD scores were below target and raised the possibility that they might be linked to low nurse staffing levels on wards. Although Directors said that these issues had been discussed at the Trust's Finance and Performance Committee, the Board itself did not formally decide in its meetings in public to take any further action on these issues or performance more generally.

Quarterly Quality and Safety Reports, including information based on feedback from patients, were presented to the Board of Directors of Northbank Hospitals throughout 2011. The Reports were presented to meetings of the Board held either in private or in public, depending on the relationship between the timetable for the preparation of the Report and the schedule of Board meetings. Reports presented to the meetings in private of the Board were made public with the subsequent month's papers for the meeting in public, but minutes of discussions and decisions in private were not made public. The Quarter 4 Report for 2010/11 was presented to the meeting in public of the Board in May 2011 and the Quarter 1 Report for 2011/12 to the July 2011 meeting in public of the Board. Following an introductory overview the Reports contained detailed information about for example mortality, medication errors, cardiac arrests, patient falls, end of life care, caesarean section rates, hospital acquired infections, clinical staff staffing levels and sickness rates. The May Report summarised information from the results of the 2010 National In-patient Survey and the Trust's local quarterly telephone survey of in-patients as they related to the CQUIN targets for five survey questions. The July Report summarised the results of the 2010 national survey for the Trust as a whole

"Patients also reported that overall satisfaction (rated 'good' or 'excellent') was now 94% in comparison to 92% last year." (Quality & Patient Safety Report Quarter One Report to End of June 2011, report to meeting in July 2011 of Board of Directors Northbank Hospitals)

At the same time the Report noted that the Trust's performance in the five CQUIN patient survey questions was not as good as its performance overall and listed a series of actions being taken to improve this performance: inclusion of survey results in agendas of performance management review meetings with directorates; rolling out the 'near patient experience' programme of collecting feedback; bespoke quality care improvement programmes in Elderly Services and Maternity. Discussion in the July meeting focused not on the results or the surveys themselves or on the

improvement action plans identified in the Report but on the recruitment and retention of nurses and on nurse staffing levels. In the words of the Chairman of the Trust in the meeting:

“The best guarantee of the quality of service is the quality of staff.”

(Chairman, Northbank Hospitals Trust meeting in July 2011 of the Board of Directors)

The Chief Nurse and the Director of Workforce both commented in the discussion on the positive results of recruitment and retention initiatives with newly qualified nurses to work in the Trust. According to the minutes, the Board noted the Report.

The most substantial regular report to the Boards of Directors that focused on patient feedback was the monthly Patient Experience Report at Hillside Hospital. There was no corresponding report at Northbank Hospitals. Evidence from my observation and from the minutes of meetings shows that discussion about the patient Experience Reports at the Hillside Board meetings focused not only on the results of the feedback (in the form of How Are We Doing? scores) itself but also on the relationships between the HRWD scores and other aspects of and influences on the quality of services. The amount of discussion varied considerably between meetings, with longer discussions at the January, April, September, October and November Board meetings than at the others. The amount of discussion appeared to be greatest in the autumn and winter months when the Trust was facing substantial service and financial pressures and the Board was most concerned about the quality of services. The discussion in January 2011 for example focused primarily on information provided for patients and on communication with patients. Directors commented on the variation between wards and divisions in HRWD scores, arguing that the overall pressures on the Trust could not explain why some services had lower scores than others. In the words of the minute of the meeting:

“The biggest single challenge is improving communication with patients. Working in a high pressure environment should not excuse lower performance. Well trained, motivated staff were expected to cope with such challenges whilst putting patients first.”

(Minutes of the meeting in January 2011 of the Board of Directors Hillside Hospital)

Directors asked about the relationships between HRWD scores on the one hand and staff sickness absence rates and hospital acquired infection rates on the other, and suggested that poor quality of services generally might be because of staffing issues.

Observation of the November 2011 Board meeting at Hillside Hospital revealed a similar focus on patient feedback in the broader context of the quality, staffing and the delivery of services. The Director presenting the Patient Experience Report said that the number of complaints had increased and that, although the HRWD hospital environment scores had risen, the scores for patients' involvement in their care and for patients' perceptions of care had fallen. She said that reports like this were a barometer of what patients were saying; it was important in the context of the difficulties facing the Trust over the next few months. As discussed at the Trust's Performance and Finance Committee that morning Divisional Managers were beginning to use the Patient Experience Scorecard in the management of services at ward level in the Hospital. Discussion at this Board meeting focused on particular domains of patient experience where there were problems – communication between staff and patients; it also focused on the use of volunteers in the hospital to interact with and support patients and on the use of drama based training with staff to help them understand issues from the patient's point of view. The minutes of the November meeting, as with other meetings in the year, recorded that the Board 'noted' the Report.

The minutes of the Hillside Board meetings in 2011 summarised the introduction by the Director presenting the Patient Experience Reports and the issues raised in discussion. In only two of the meetings was any action arising from the Reports or discussion identified in the minutes; once to ask for changes in the ways results were presented in the Reports to the Board; and on the second occasion to ask the Executive Director of Operations to prepare a report for the Board on responsibility for the availability of hand cleansing gels. In all the other meetings the minutes simply summarised the issues discussed by the board; half of the minutes also said that the Board noted the Report. This evidence, along with the fact that the Patient Experience Report at Board level was a self-contained document that did not refer directly to the Trust's service and resource priorities as identified for example in the Annual Plan, suggests quite strongly that patient feedback was not used by the Board of Directors at Hillside to help monitor and manage the Trust's overall priorities for the Hospital.

Observation of the discussions and absence of decision-making about the Patient Experience Report at the Hillside Board meetings led me in the course of fieldwork to ask specific questions in interview: if the Board was not making decisions about patient feedback, why did it receive the reports and what it was using them for? Two broad themes emerged in the answers: that patient feedback was used to inform

specific decisions in other areas such as the quality of services; and that the purpose of having the Patient Experience Reports on the Board's agenda was not so much to inform specific decisions as to influence the overall perceptions of the Board and the priorities in the Trust as a whole.

The view that feedback from patients was used to inform a variety of decisions by the Trust Management Executive and the Board was expressed most clearly by Corporate Director WT, who was herself responsible for presenting the Patient Experience Report to the Board. She was asked in interview what the Board of Directors used patient feedback information for.

“Well I think they use it to inform their decision making across a whole raft of different areas. And it may not be apparent at every Board meeting what those decisions that they might or might not be making are. ... But of course, what it does do for the Board of Directors is I think it focuses, when they come to think about ‘well where are we actually going to,’ in terms of the Trust strategy and overall direction, ‘where are we going to focus our efforts?’ It helps to focus those priorities.” (Corporate Director WT, Hillside Hospital)

WT then developed the idea about specific influences further. She talked about the use of feedback in the Trust's Transformation Programme, including the food and feeding initiative and the quality improvements included in the Trust's Quality Accounts. In Chapter 4.6.2 I showed how the food and feeding initiative was prompted, in the context of regulatory changes and the actions of regulatory bodies, by the results of the 2009 national in-patient survey. In Chapter 4.5 I outlined the Trust had difficulties in achieving in 2010/11 across the board improvements in its patient experience CQUIN targets; in 2011/12 the Trust adopted the less ambitious target of increasing consistency of patient experience across the Trust by improving the HRWD scores in the six worst performing wards. This evidence suggests that patient feedback was used in the Trust to support decision-making directly related to patient experience. But, despite the view of Corporate Director WT, my evidence does not itself demonstrate that patient feedback was substantially used to influence priorities and decision-making in Annual Plans or other contexts about the delivery of services and use of resources more generally.

The Directors interviewed at Hillside Hospital also said quite clearly that patient feedback was used more broadly by the Board to inform the overall perspectives of the Board and the priorities of the Trust. Executive and Corporate Directors were asked in interview what the Board used patient feedback for.

Interviewer “The Board of Directors meets in public, meets in private. In what ways do you see the Board of Directors as actually using patient feedback?”

BT “Actually I think our Board of Directors are very focused on patient feedback because – particularly the non-execs, but I think the executives as well because I think we do all feel that, you know, part of our remit is to make sure that we are running a patient focused, safety orientated organisation.” (Executive Director BT, Hillside Hospital)

In answering the question, BT identified no clear use of patient feedback. He was perhaps implying in his use of the words ‘... our remit is to make sure ...’ that the Board used feedback to help assure the quality of services; but this is not absolutely explicit. The more general implication is that the Board is responsible for the quality of services, and that feedback from patients can help them fulfil this responsibility.

Other Directors gave a similar answer to the question. I have quoted above Corporate Director WT’s view that patient feedback helped the Board focus on the strategy and overall direction in which the Trust was travelling. It was partly about the external context, interest from the Department of Health, in the context of the Mid Staffordshire Hospitals crisis, in real time patient feedback; and partly about the influence of senior executive directors in the Trust.

Interviewer “Coming back to the Board of Directors meetings, the Trust Board meetings, there’s a regular presentation of ... and discussion about Patient Experience Report. But in the meetings I’ve been in attendance at there are very few actual Board decisions based on the reports, very few direct actions coming from them. Why?”

LS “Well, because the reason that is there, if you want to be brutally frank and honest, is when I arrived in November 2008 I didn’t think there was ever anything came to the Board about patients. It was all about numbers. And so you know I wanted there to be at least one agenda item every month that had quality at its heart. And that’s it. It’s just there to keep it above – in the sunlight.” (Executive Director LS, Hillside Hospital)

Keeping it ‘in the sunlight’. The purpose of presenting patient feedback to the Board of Directors was in this view not to inform specific decisions or to lead to specific actions but to counterbalance other kinds of information that were presented to the

Board and, perhaps, to influence the overall perceptions and priorities of the Board. But what LS did not make explicit here was the 18 month gap in time between his arrival in the Trust and the first presentation of the Patient Experience Report to the Board of Directors. In the meantime the first Francis Report into the Mid Staffordshire Hospitals was published and the attention of the Department of Health and regulatory bodies was focused more clearly on the use of feedback from patients and relatives to help assure the safety and quality of services. The implication, quite possibly, is that the Francis Report itself prompted the view that patient feedback should be used not for any specific decisions but to ensure that Boards had a rounded perspective of the quality and provision of services and that this perspective was visible to everybody, inside and outside the Trust. It is in this analysis difficult to demonstrate that patient feedback is used explicitly and directly to improve services. Patient feedback might in fact not be 'used' at all in the sense of it leading to specific decisions and actions. It is instead, in this interpretation of this evidence, part of the context in which decisions about services and resources are made.

6.5 'Improving Out-patient Experience' at Northbank Hospitals

In the previous sections of this chapter I have shown that, although Boards of Directors and managers say that they will use feedback from patients to assure and improve the quality of services for patients, it is sometimes not absolutely clear how Boards actually do this, what decisions they make and what actions they take using feedback from patients. At the start of fieldwork in January 2011 I attended a meeting in public of the Board of Directors of Northbank Hospitals NHS Foundation Trust. In the course of a full agenda, including items on service development, planning and performance management, finance and savings, the Board discussed the notes of the Council of Governors Patient Experience Working Group that had been held in November 2010 and included an item on key themes from complaints and patient surveys. The Lead Governor highlighted (in the words of the minutes of the January Board meeting) 'the re-emergence of problems with appointments, telephones and receptionists which it was hoped would be tackled quickly'. In this section I examine the ways in which the Board of Directors at Northbank Hospitals used feedback from patients to make decisions about the out-patient improvement initiative and to monitor the effects of those improvements.

In this section I draw on three sets of data from Northbank Hospitals. Agenda papers and minutes of meetings in public of the Board of Directors, and minutes of meetings of the Council of Governors and its working groups, provide information

about the formal structure of and decisions about the initiative to improve out-patient experience. They also provide more detail about the initiative than I collected from other sources. My own notes from observation of Board meetings supplement the papers and minutes by providing a more informal account of who said what in the meetings. Data from interviews provides a series of differing perspectives from the points of view of the different interviewees on the use of feedback in the origins and assessment of the initiative. Material from these different sources is analysed here to produce a narrative account of the ways in which the Board of Directors responded to and used the feedback from patients.

The minutes of the January 2011 Board meeting at Northbank Hospitals spoke of the 're-emergence' of problems in the administrative support for out-patients and out-patient services. The problems were identified at least in part as a result of complaints from patients. Following a discussion of the Trust's Quarterly Quality and Patient Safety Report at the Board meeting in November 2010, the minutes said that the Board encouraged the use of 'mystery shoppers' particularly on administrative processes, telephones and appointment systems that were the subject of complaints. The papers for the January 2011 meeting of the Board of Directors included the minutes of the meeting of the Council of Governors Patient Experience Working Group also held in November 2010. The minutes of this November Patient Experience Working Group in commenting on key themes from complaints and patient surveys said that the Trust needed to address problems that had not yet been tackled, in particular the administration of appointments, telephone systems and communication, the provision of information to patients having to wait a long time in out-patient clinics, and staff communication and customer service for patients. Because the Trust's surveys of patients at that time focused on in-patients, it is likely (on the basis of this evidence) that most of the issues brought at this time to the attention of the Council of Governors and the Board of Directors about out-patients were derived from patients' complaints and comments.

The evidence from the Board of Directors and Council of Governors papers suggests that patients' complaints were the primary source of feedback that led to the out-patient improvement initiative. This view is supported by some interview data. Corporate Manager IN was asked early in the data collection for an example of changes that were occurring in the Trust because of patients' complaints or other kinds of feedback. She described complaints about the problems patients had in making, confirming or cancelling appointments and in getting telephone calls

answered or returned. When asked in interview how she knew that the changes were the result of complaints and feedback from patients she said:

“ ... it was something I raised at the Patient Experience sub-group of the Governors, and one of the Non-execs was there who wanted to hear about what our key issues were, and was very interested. I know it's been discussed that that is sort of the big area of our complaints, and I know that it was because of complaints why they're doing it. But I don't know if it's documented anywhere that that's the instigator.” (Corporate Manager IN, Northbank Hospitals)

According to IN it was the complaints that made the difference and led to the out-patient improvement initiative. Although she did not know if there was documentary evidence about the influence of complaints, she was clear in her own mind that complaints were important. And, in making her claim, she drew attention to the organisational route through which the complaints began to be noticed and have an influence: the Patient Experience Working Group of the Council of Governors and the personal interest at the Working Group meeting of one of the Non-executive Directors of the Trust.

Despite this view, other interviewees provided different accounts, with different emphases, of the origins of the initiative and of the extent to which it was the result of feedback from patients. Corporate Nurse Manager VL when asked in interview about the origins of the out-patient experience initiative said that, following a reorganisation of management responsibilities in the Trust in the summer of 2010, she took up responsibility for the elective patient pathway:

“Well it's a piece of work I initiated, so it was me that decided to do this. And was aware of some, it started from realising that our abandoned call rate was too high. And the reason I discovered this was partly about hearing anecdotal complaints from patients but also, because we had call centre technology put in, so I could actually see it, I asked for it at a, I was seeing aggregated data and I asked for a breakdown and it was the breakdown that was so much variability. So the original piece of work started off as simply to reduce the abandoned call rate. And then we sort of moved it into a piece about improving the outpatient experience specifically.”
(Corporate Nurse Manager VL, Northbank Hospitals)

Here VL claimed that she initiated the improvement initiative. The prompt was partly ‘anecdotal’ complaints from patients and relatives. Because new telephone

technology had been installed in the Trust, she was able for the first time to look at the telephone abandoned call rate and began to examine the issues more closely. For VL it was the objective, operational data that were important. For her, feedback from patients and analysis of information derived from the Trust's operational systems sat alongside each other in beginning to identify issues to be addressed and improvements that were needed.

The analysis so far indicates that complaints and other kinds of patient feedback were mediated through a variety of organisational processes leading to discussion and decisions by Boards of Directors. Governor SG talked in interview about how discussions at the Governors' Patient Experience Working Group could make a real difference to what managers do and what happens in the Trust:

"But when they're at the Board meeting, that's when I really try and nail something down. I mean I nailed down all this business about out-patients. And the out-patients were not getting – the efficiencies, the inefficiencies were awful in out-patients with the telephone system and the clinics and everything else. And with the support of one non-executive director we really got the ball rolling on that." (Governor SG, Northbank Hospitals)

When SG was asked where she got the information about the difficulties with out-patients and telephones from she replied:

"It came from surveys, yes. It came from feedback, yes. It came from talking to people living locally, and patients you know, And so it was a general feeling, and also particularly this one non-executive director who'd had a lot of – he'd had some in-patient treatment and out-patient treatment, and he really supported me on this, and we got it moving." (Governor SG, Northbank Hospitals)

Here SG identifies three sources of feedback – surveys, talking informally to local people and patients, and an individual's personal experience – that contributed to the improvement initiative. But, despite Governor SG's statement about the role of surveys, the 2009 national out-patient survey and the Trust's quarterly telephone survey of patients asked no questions about telephone contact and communication about out-patient appointments and there is no other evidence from other documents or interviews that any other surveys of patients in the Trust highlighted out-patient issues at the time. Complaints and informal comments and discussions appear to have been the main sources of feedback that led to action.

Despite the difficulty of corroborating the details of each of these statements, they can be put together into a coherent account that identifies the role of different kinds of patient feedback and other factors in the development of the improvement initiative. Some managers in the Trust were aware in mid-2010 that out-patients and others were having difficulties in using telephones to access the Trust's services and began a piece of work to put things right. Complaints about telephones and other aspects of out-patients' appointments were discussed at a meeting of the Council of Governors Patient Experience Working Group in November 2010. They were raised by the chair of the Working Group at the Board of Directors meeting in January 2011. They were discussed at a meeting in private of the 'Board in Committee' in February 2011 and, as part of a wider discussion about the Trust's patient experience and quality strategy, again in March. The paper for the March meeting said that the Board was 'committed' to making improvements, a commitment that was presumably made in private at the February meeting. In this sequence of events no single source of feedback from patients on its own pushed the Trust into taking action. Complaints and the personal experience of one non-executive director appear to have been important. Feedback from patients along with a variety of other local information and awareness, derived from personal contacts and knowledge and from the Trust's operational systems, led to the view that something was wrong and needed to be addressed. The immediate impetus for the Board of Directors itself to take note and address the issues came from pressure from Governors.

Following the Board of Directors' commitment to improve services, a report to the Board in April focused on the actions to be taken to improve the out-patient experience and the service standards and systems of measurement that would be established to ensure that improvements were made. The paper 'Improving Out Patient Experience' was described in the minutes of the meeting as an 'Operational Update'. The Board was not asked to make any formal decisions about the paper, but according to the minutes welcomed it and asked for a further report to the July meeting. The main body of the April paper reported on progress to date with improving the experience of out-patients, immediate and second-stage priorities for action, key performance indicators and additional indicators. The immediate priorities for action included improving communication: reducing the number of abandoned telephone calls, improving the timeliness and content of written communication, setting a maximum waiting time within clinics of 30 minutes, and developing behavioural standards with staff. Second-stage priorities included developing a more consistent approach to patient booking and appointment teams, and taking '... a more

comprehensive approach to involving patients in the development of services and the assessment of the less measurable elements that contribute to patient experience.’ Service standards and timetables for improvement were set. Progress would be measured by a series of quantified performance indicators, including for example the abandoned call rate, call answering time, the amount of notice given for an elective out-patient appointment, and the proportion of elective out-patient appointments agreed directly with the patient. In addition ‘a range of other softer measures’ would be developed: patient surveys to capture the patient perspective and identify other priority areas, for example, behaviour and attitude; regular review of complaints and PALS contacts; and structured management walkabouts and patient interviews. The paper thus indicated that, although the out-patient improvement initiative had been prompted by patients’ complaints being brought to the Board of Directors by Governors and the Council of Governors’ Patient Experience Working Group, first priority would be given to improvements and the measurement of improvements not directly in terms of the experience of patients but in terms of operational measures of service performance.

The paper prepared for the July 2011 meeting of the Board of Directors focused on the actions being taken to improve service but contained very limited information about the standards or measures of improvement. The paper set the out-patient initiative in the context of the NHS Outcomes Framework and the development in the Trust of a new quality strategy. It commented

“There seem to be two really consistent themes coming out of all the outpatient experience work, the first is about needing to make it easier for patients to communicate with the trust and the second is about staff attitude and behaviour, there is very little criticism about the quality of the clinical interaction in outpatients.” (Improving the Patient’s Experience Update Report, presented to the meeting of the Board of Directors Northbank Hospitals July 2011)

A Trust-wide Out-patient Steering Group had been established and Directorate Improvement Groups, with clear objectives and firm delivery dates, were being established. The objectives for the Directorate Improvement Groups were set in terms of operational measures of performance rather than in terms of surveys or other direct reports of patient experience. The paper reported to the Board of Directors progress in communication, telephone access and out-patient appointments, in improving the quality of patient reception services. It provided detailed information about the actions being taken to improve services, including for example developing e-mail and mobile

phone booking of out-patient appointments and the training of reception staff in high standards of communication with distressed patients. But at the same time the paper reported to the Board actual progress in relation to the operational measures that had been identified in the April paper only in terms of the abandoned phone call rate; it did not report at all on the results of 'softer' patient experience measures or on progress with the development of those measures. This analysis is confirmed by my observation notes and the Trust's formal minutes of the meeting: the only actual measure of performance or patient experience identified in the presentation or discussion related to telephone abandoned call rates. Despite the claim of the paper to be 'improving out patient experience' it provided very little information for the Board directly about the experience of out-patients.

Despite the limitations of the information presented to the Board, the minutes of the July meeting said that the Board of Directors welcomed the progress made so far with the initiative and 'the improvement in the indicators'. The minutes of the July meeting also said that the Board '... looked forward to receiving ... future regular reports on this subject in the operational performance report and a comprehensive update in November.' Examination of Board agendas and papers for the meetings of the Board of Directors in 2011 and 2012 shows that this did not happen in the meetings in public of the Board within this time frame. Information about out-patients in the regular performance reports related only to the number of out-patient appointments rescheduled by the hospital and to reductions in the number of out-patient DNAs, not to any of the performance or out-patient experience measures identified in the April 2011 Board paper. There was no 'comprehensive update' on the out-patient improvement initiative provided to the public meeting of the Board of Directors in November 2011 as had been requested in July, or in the form of a written report to meetings in public of the Board at any other time in 2011 or 2012. The minutes of the November meeting did however say under Matters Arising (referring back to the meeting of the Board in March) that Chairman had suggested that the current action was now complete and that there should be a further discussion about patient experience at the joint meeting of the Board and Council of Governors in April 2012.

The meeting of the Council of Governors in April 2012, with the full Board of Directors in attendance, was presented with a verbal update about the 'improvements in front end processes'. The minutes of the meeting indicate that the presentation focused on the actions taken to improve the out-patient services, as distinct from measures of operational performance or patient experience assessing or monitoring

the effects of those actions. The improvement programme had included the production of standard operating procedures for out-patient appointments by all directorates, the production of training competency maps and performance indicators by all directorates, the establishment of the telephone academy, the introduction of a dedicated appointment cancellation line (but not yet of a system that enabled patients to make a new appointment at the same time), and the introduction of text messaging to remind patients about appointments. The only measure of operational performance or patient experience reported in the minutes of the meeting was a reduction in the abandoned telephone call rate from 40 percent to less than five percent. The minutes of the meeting noted that the PEWG lead had welcomed the Trust's continuing programme of work in this area; the minutes identified no other comments about patient feedback or experience. Although the out-patient improvement initiative had begun at least in part with complaints from patients and feedback of individual governors' and non-executive directors' experience, the focus in reporting to and discussion by the Board of Directors was on the practical activities and changes in the services that were being introduced; criteria and standards of success, in so far as they were reported to and discussed by the Board of Directors at all, related to a very small number of performance indicators – the number of abandoned telephone calls and the number of out-patient clinic DNAs – rather than to any other direct measures of patient experience or patient feedback.

The evidence from the papers and minutes of the Board of Directors in 2011 and 2012 thus shows that, although the complaints and comments from patients played a substantial part in the origins of the out-patient improvement initiative at Northbank Hospitals, the Board subsequently focused on the actions being taken to improve the service rather than on feedback from patients to assess whether or not the service had actually improved. The evidence here therefore tends to confirm the evidence I presented in earlier sections of this chapter that the Board of Directors at Northbank Hospitals did not itself in 2011 use feedback from patients routinely to monitor progress of quality improvement initiatives or on a regular basis to assure the quality of services.

6.6 Summary

In Chapters 4 and 5 of this thesis I showed that managers in hospitals use different kinds of feedback to help improve and set standards for the quality of services and to manage and motivate the staff who provide those services. In this chapter I have examined what the Boards of Directors at Hillside and Northbank

Hospitals say about how they themselves will use feedback from patients and how they actually have used it. I have argued that Boards say they will use patient feedback to assure and improve the quality of services but that there is a lack of clear and direct evidence that they do actually use it in the ways that they say they will.

In Section 6.2 I showed how the publication in 2010 of the Francis Report about the Mid Staffordshire NHS Foundation Trust prompted reviews at Hillside and Northbank Hospitals of the ways in which feedback from patients about their experience of the quality of services was reported to the Boards of Directors and about how the Boards assured themselves of the quality of services for which they were responsible. The Board of Directors at Hillside began in 2010 to receive regular Patient Experience Reports showing the detailed results each month of the Trust's local How Are We Doing? survey of patients. It developed explicit standards to help assure and improve the quality of services. The Board at Northbank initiated a more substantial review of patient feedback and developed a broader quality strategy. The strategy included a small number of explicit standards or targets for improving the quality of services; but the Board did not during the time of fieldwork for this study receive any reports showing the results of patient feedback about the patient experience priorities and improvements that had been identified in the strategy.

The Francis Report raised questions about the use by Boards of Directors of feedback from patients to help assure the quality of services for patients. I showed in Section 6.3 that legislation and the requirements of regulatory bodies require Boards to use patient feedback to monitor the quality of services. Although it might be argued that the consideration by Boards of the results of patient feedback could be considered implicitly to contribute to the assessment and assurance of quality, the Boards themselves did not explicitly and directly use patient feedback in their meetings in public for quality assurance. Reports from the Committees to meetings in public of the Boards did not provide explicit evidence that the Committees used patient feedback to help assure the quality of services. I discuss this issue in more depth at the end of Section 7.2.3 in Chapter 7.

The lack of explicit detailed evidence about the use of feedback by Boards to monitor strategies or assure the quality of services raised further questions about the actual use by Boards of the feedback that was reported to them. In Section 6.4 I examined the use that is made of patient feedback that is reported to Boards in Chief Executives' Reports, Performance Reports and other Patient Experience and Quality Reports. The Chief Executive's Reports and Performance Reports at Hillside included information about patient feedback more frequently and in a wider context than those

at Northbank; the Board at Hillside discussed issues related to patient feedback more frequently than the Board at Northbank. The Board at Hillside, unlike the Board at Northbank, received and discussed at its meeting each month a 'Patient Experience Report' based on feedback from patients. But despite the detailed information in the Report and the amount of discussion the evidence from documents, observation and interviews showed that the Board did not use this feedback directly to make decisions about the improvement of services. The evidence from interviews suggested the feedback may influence the overall perceptions and priorities of the Board, feeding into discussions about Annual Plans and Quality Accounts; more detailed research focusing on the internal management processes of Trusts would be needed to test this proposition more closely. This is an issue I re-visit in Section 7.3.4 in Chapter 7.

Finally in Section 6.5 I examined an initiative to improve out-patient experience at Northbank Hospitals. The initiative was established in the Trust partly as a result of complaints by patients and partly on the basis of information from operational systems about the telephone service for patients and others trying to contact the hospitals. The Board of Directors took on a commitment to improve the service as a result of feedback through and pressure in Board meetings from Governors. The Board approved a paper containing a detailed action plan to improve the delivery of services and a wide range of quantitative performance measures and 'softer' measures of patient experience. Subsequent reports to the Board described the actions being taken but contained very little information based on operational measures of performance and no information based on patient feedback about patient experience. The evidence shows that, although the initiative to improve out-patient experience had in part originated from feedback from patients to the Board of Directors, the Board did not continue to use feedback directly to assess the effects of the initiative.

The findings in this chapter lead therefore to the unexpected observation that the Board of Directors at Hillside Hospital had detailed data about patient feedback but not the service strategies to build on and make use of that data; whereas the Board at Northbank Hospitals had substantial strategies for service improvement, both as a result of their Quality Strategy and as a result of the out-patient improvement initiative, but did not use the limited feedback data that were available to them to monitor the implementation and success of those improvement strategies. One Trust had the feedback data but not a strategy for its use; the other Trust had a strategy but did not use its limited feedback data to monitor the implementation and assess the

results of the strategy. The collection and availability of feedback do not determine the use of feedback.

Chapter 7 Discussion and Conclusions

7.1 Introduction

In this thesis I have examined how feedback from patients is used in the management of hospitals in the National Health Service in England. I have drawn data from government policy and guidance and from detailed qualitative study of two NHS foundation trusts. In Chapter 4 I examined the ways in which different kinds of patient feedback are used to improve services. In Chapter 5 I examined how patient feedback is used to influence and manage the staff who provide treatment and care for patients; and in Chapter 6 I examined how the Boards of Directors of the two foundation trusts use feedback in carrying out their responsibilities. In this chapter I discuss, in the context of the research literature about patient feedback that I reviewed in Chapter 2, the empirical and theoretical implications of my findings.

In Section 7.2 I discuss my findings in the context of the published research literature about the use of patient feedback, examining the implications of the literature for the interpretation of my findings and the implications of my findings for the patient feedback research literature. In Section 7.3 I draw conclusions from my research and summarise the contributions of this study to our knowledge of the use of patient feedback. I then examine the implications of the research for the development of policy and practice in the National Health Service and health services more generally. After examining the scope and limitations of this study I conclude the thesis with an analysis of the implications of this study for the development of future research on patient feedback and its use in the management of health services.

7.2 Discussion

In Chapter 2 I noted that there were no formal definitions of the term 'patient feedback' in the research literature and commentaries that I had reviewed for this study. I provisionally defined patient feedback as 'information about a patient's use or experience of health services provided (intentionally or not) by the patient (or someone else acting on her / his behalf) to the provider of services (or someone working on the provider's behalf).' In this study I found no definitions or other information that indicated that this was a totally inappropriate definition and would suggest therefore that it could serve as a starting point for any further investigation and analysis.

Although this research has focused on the use of patient feedback in the management of hospitals, I deliberately refrained in the Literature Review from attempting to define the everyday word 'use'. The evidence presented throughout this thesis is that patient feedback is used in a variety of ways, in analysis and assessment, in benchmarking and comparisons, in planning and decision-making; it is used to improve not only services or the quality of services but also to influence staff and the management of services more generally. These are all organisational processes that are not specific to any one substantive aim of using feedback. In understanding the ways in which feedback is used (or the word 'use' is defined) it is important to keep in mind the variety of organisational processes that may be involved and not unintentionally to exclude them by an inappropriate a priori definition.

7.2.1 Patients and Improvement

In Section 2.5 I identified many examples of research papers and commentaries (from the initial study of Tasa et al. (1996) to the reviews and secondary analyses of Raleigh et al. (2012) and Locock et al. (2014)) that assumed that the purpose of collecting and using feedback from patients is to improve some aspect of health care or the provision of health services. I argued that the practical literature and empirical research papers about patient feedback are often not clear about what they meant by 'improvement' or explicit about how improvement would be assessed. I therefore drew on a wider public service improvement literature (e.g. Boyne 2003, Talbot 2010) to help identify not only concepts of improvement but also ideas about the criteria and standards by which improvement could be judged. This public service improvement literature itself tends to focus on the use of quantified measures of performance as the best indicators of improvement in the quality of services.

The findings I presented in Chapter 4 help get beneath the surface of the variety of ideas about improvement contained in the empirical research studies and reviews of patient feedback (e.g. Brooker and Dinshaw 1998, Coulter et al. 2009, Entwistle et al. 2012). The research studies focus on improvement of many different aspects of services – clinical care, quality, access, safety, the attitude and behaviour of staff, the quality of food, the cleanliness of wards and departments etc. My data in many ways confirm the findings of these studies, demonstrating the variety of domains of feedback and the different aspects of clinical care and services about which patients provide feedback. But the diversity of feedback is not always reflected in the management systems that report and make use of it. I showed in Section 4.5 that the formal reporting of feedback focuses on survey results and quantified targets. The

detailed evidence about the use of an aggregated survey score for assessing the results of the food and feeding initiative at Hillside Hospital and about the use of the abandoned call rate as the only indicator of success of the out-patient improvement initiative at Northbank Hospitals provide clear examples of this highly focused use of specific evidence to assess and monitor improvement in services. The breadth of the aims of improvement initiatives as reported in the literature is often not reflected in the specificity with which progress and improvements are monitored, a finding consistent with the view of Bevan and Hood (2006) that 'what's measured is what matters'.

In Chapter 2.4 I noted that it is often difficult to identify from previous studies of patient feedback and classifications of the domains of feedback (such as patients' complaints) the exact nature of the contents of the feedback. This is especially true of the relationship between clinical and non-clinical domains of feedback. The Darzi Report (Department of Health 2008b) was itself unclear in its analysis of the quality of health care in terms of outcomes, safety and patient experience. More recent policy about PROMs and research literature about patient safety (Giles et al. 2013, McDonald et al. 2013) have focused on patients' experience of outcomes and safety. Although most surveys of patients, including the annual national survey of in-patients and the local surveys at Hillside and Northbank Hospitals, focus almost exclusively on what might be seen as patient experience of non-clinical issues, the issue is complex. Many questions in surveys are about issues such as noise, food, and communication which are at one level 'hotel' services. But at another level, these are clinical issues: the amount of noise in a hospital ward and the acceptability of food may affect a patient's well-being and recovery; communication between staff and patients may be a question of 'customer care' but it may also be an integral part of clinical treatment. Although some managers I interviewed drew a distinction between clinical treatment which was the realm of professional expertise and patient experience which was the legitimate subject of patient feedback, other managers and clinicians did not. Surveys are not usually about the appropriateness of assessment, the accuracy of diagnosis, and the appropriateness and effectiveness of treatment, but some survey questions (e.g. about the control of pain) and some complaints by patients are about the accuracy of diagnosis and the appropriateness of treatment. The General Medical Council's (2012) questionnaire for the appraisal and revalidation of doctors asks patients how good their doctor was at assessing their medical condition and providing or arranging treatment. The evidence suggests that the relationship between clinical and non-clinical domains of patient experience and patient feedback is at best unclear. It appears to be an issue on which ideas and

practice are developing alongside each other; patients are more and more being asked to provide feedback about clinical aspects of diagnosis and treatment.

In Chapter 3 I discussed the analysis of Shaw et al. (2004) of policy documents in terms of their empirical, rhetorical and ideological content. The data I have presented here develops their analysis in two ways. First, it is of course not simply documents or government policy documents that display these characteristics. What people say in interview and what they say and do in meetings and other working environments also have empirical, rhetorical and ideological contents. Second, my data about the ways in which people think and talk about 'improvement' suggest additional kinds of content and use-in-practice. The idea of improving services is in part 'rhetorical'; who could disagree with improving the quality of care? It is also in part empirical; improvement is, as I have shown, measured (if incompletely) in a whole variety of ways. But the relationship between the rhetorical and empirical content gives rise to an additional area of meaning: specific ideas about improvement provide a frame of reference, a way of thinking about health care. Saying that feedback from patients is used and should be used to improve the quality of care helps shape organisational practice in the provision and management of services.

Within the framework of recording and measurement of patient feedback, one of the things that is new in my findings is the emphasis I place on the distinction between feedback about the subjective aspects of patients' experience – how patients feel when they are ill and in hospital – and feedback about the health care that they have received or the services they have used. This distinction is absent from much of the empirical patient feedback literature (Spencer 1996, Coulter et al. 2009, Parry and Hewage 2009); it is implicit but not highlighted in the analysis of Entwistle et al. (2012). I build on the distinction by showing that these different kinds of feedback are used in different ways in the management of services. Although managers do listen to feedback about patients' subjective experience and sometimes use it to motivate staff, they then tend to use this feedback not with the aim of improving patients' subjective experience per se but with the aim of improving the quality of services in ways that they (the managers) themselves define and measure. I showed in Chapter 4 that the questions in surveys of patients and hence the results of the surveys do not focus primarily on patients' subjective experience of services, on their stress or distress while using services; they focus on the services themselves. It is the results of these surveys that are the main set of patient feedback that Trusts and managers use to help assess the quality of services. The subjective aspects of patients' feedback are not reflected in the formal performance measures that are used in the

management of services. My evidence therefore supports an argument derived from the review of Coulter et al. (2009) that different kinds of patient feedback are used in different ways. It also develops, substantially beyond the analysis of the domains of feedback that I presented in Chapter 2.4, the new argument that feedback about different domains of feedback – especially the subjective nature of patients' experience – is used in different ways in the management of services.

Government policy, health service managers and other people freely use the phrase 'patient experience' but often are not rigorously clear what they mean by it. 'Patient experience' is often used to refer both to the ways in which health care is delivered (i.e. the objects and services that patients experience) and to how patients feel about their illness and health care (i.e. the subjective nature of those experiences). The Darzi Report (Department of Health 2008b), itself one of the main channels through which the phrase became widespread in the NHS, perhaps added to the confusion by describing patient experience in terms of the compassion, dignity and respect with which patients are treated and of 'patient satisfaction with their own experiences'. Although few of the empirical research studies I reviewed in Chapter 2 draw out the distinction between the subjective and objective aspects of patient experience, or make explicit the conceptual relationships between patient experience and patient satisfaction, the research and analysis of Entwistle et al. (2012) has helped clarify the issues. Entwistle et al. emphasised crucial distinctions between the characteristics of health care staff, the behaviours and actions of staff, and the ways in which these actions enable patients to be and to do what they themselves value. My findings and analysis in Chapter 4 correspond broadly to these distinctions: my focus on the ways in which health care is delivered corresponds to the analysis by Entwistle et al. of the actions and behaviours of health care staff; my focus on how patients feel about their illness and health care corresponds broadly to their analysis of what patients value. But in addition my findings focus more explicitly than did Entwistle et al. on the subjective feelings – the stress and distress, the anger or gratitude – experienced by patients while they receive health care and use health services.

One substantial implication of this emphasis on the subjective aspects of patient experience, as identified by one of the managers I interviewed, is that it is not the views of clinicians or managers that matter in assessing the quality of services but the experience and views of patients themselves. None of the patient feedback research literature that I reviewed in Chapter 2 pushes the analysis this far. My argument here is that this analysis, although extreme, is worth taking seriously

because it then requires us to think carefully about the relationships between patients' subjective experience, patient satisfaction, and patients' views about the health care they have received. It requires researchers studying the collection and use of feedback from patients to be clear about the conceptual basis of their empirical data. It requires policy makers and practitioners to think carefully about the criteria and judgements that are used in making decisions about improving services; what are the criteria of improvement, what do we mean by improving services?

Following earlier suggestions (e.g. Jonsson and Ovretveit 2008) that feedback from patients could be used to help improve the safety of services and in the presence of major public and political concerns about the quality and safety of services (as evidenced by the Mid Staffordshire Trust inquiry report of 2010), Government policy and legislation in England have required providers of health services to use feedback from patients to help protect patients from the risks of unsafe care. Recent research literature (e.g. Giles et al. 2013, McDonald et al. 2013, Berger et al. 2013) has begun to examine the potential and the feasibility for using feedback to improve safety. The findings from fieldwork in 2011 that I reported in Chapter 4 contained very little direct evidence that patient feedback was being used at that time for this purpose. This may be a result of the limitations of my data – I did not observe meetings in private of the Trusts' Safety and Quality Committees; Trusts (and other organisations) are more likely to discuss risks and safety problems in private than in public. The main evidence from my data related to the use of feedback about the cleanliness of wards to support initiatives to reduce the amount of hospital acquired infections, itself the subject of specific government initiatives and regulatory targets. But the facts, that interviewees talked at length about the use of feedback to improve quality but not about its use to improve safety and that Trust documents that were made public did not talk (even in general terms) about the use of feedback to help improve safety, indicate that at least that there were no explicit policies and procedures in the Trusts for its use for this purpose.

If this analysis is correct, the timing of developments in policy, practice and research has implications for our understanding of the use of feedback. Although complaints systems and surveys in 2011 generated substantial amounts of data about a wide range of patient experience and service issues, the research effort at that time was focusing not on the ways the existing data might be used to improve safety but on the development and testing of new tools and techniques for collecting feedback relating specifically to safety. This analysis suggests that we may in future see the development of different methods of collecting feedback about specialised topics – a

trend that I reported in my analysis in Chapter 4 in examining the monitoring of the food and feeding initiative at Hillside Hospital. It confirms my starting point for this study, that practical and research attention tends to focus more on the collection than on the use of patient feedback. It also implies that practical and research attention should in future focus on the variety of uses in a variety of contexts of different kinds of feedback about different domains of patient experience and health care. It points towards the development of increasingly detailed and specialised areas of feedback and the use of feedback.

The public service management literature (Boyne 2003, Talbot 2010, Boyne et al. 2010) that I reviewed in Chapter 2 focused on quantified measures of performance as indicators of improvement in the quality of services. My findings in Chapter 4 show that this literature does not itself provide a completely satisfactory framework for analysing the ways in which patient feedback is used to help 'improve' health services. In part my argument is that the inputs, process, outputs model from the public service improvement literature (Talbot 2010) (which in the case of health services can be traced back at least as far as the systems-based analysis of Donabedian 1980) fails to take account of the interactions between service users and service providers in the production and delivery of services. It is these interactions, encapsulated in such phrases as 'privacy and dignity' and staff 'attitudes, behaviour and communication', that are central to patients' experience of health care. But my further argument here is that the performance measures described in the public service management literature do not take account of the subjective experience of service users, the feelings of stress and distress or of gratitude and relief that patients experience while using services. In both these ways the public service improvement literature fails to reflect the reality of patient feedback in health services. The empirical data about the nature and use of patient feedback suggest that the subjective perceptions of service users and the ways in which users interact with service providers should both be incorporated in the systems-based analytical frameworks presented by Talbot and Boyne et al.

Although the patient feedback and public service improvement literatures I reviewed in Chapter 2 talked extensively about improving the quality or provision of services, they said little about the ways in which standards for improvement are set in health services. The studies about patients' complaints (e.g. Hunt and Glucksman 1991, Hsieh et al. 2005, Parry and Hewage 2009) assume, as did the managers I interviewed at Hillside and Northbank Hospitals, that reductions in the number of complaints are an improvement. But there appears to be little analysis of the

possibility that changes in the number of complaints may reflect changes in systems that make it easier or more difficult to complain; there is little analysis of variations in attitudes and expectations among staff and patients that may lead to differences in the number of complaints in different wards or services. The evidence I presented in Chapter 4 shows that, for all practical purposes, managers take the substance of complaints as an indicator of the quality of service; they take a reduction in the number of complaints as an improvement in service. But, judging from the weight and details of the evidence I presented in Chapters 4 and 5, it is the individual complaints or groups of complaints rather than strictly numerical or statistical analysis that give rise to specific management actions to investigate and improve the quality of services. Although the public service management literature might lead one to expect that the numerical measurement and reporting of complaints would contribute most substantially to improvement initiatives, my findings suggest that it is the significance and severity of individual events, rather than the numbers themselves, that lead to action. The implication is that service development, and further research, should focus as much on the criteria and standards by which managers make judgements about individual events as on statistical trends and analysis.

Studies based on surveys of patients (e.g. Brown et al. 2009, Raleigh et al. 2012) nevertheless often base notions of improvement directly on the scoring systems and results of the surveys themselves. In Section 4.5 I presented evidence about the ways in which these scoring and reporting systems are themselves used by Trusts to set standards for services and targets for service improvement. These standards may (as in the food and feeding example at Hillside Hospital) themselves be based directly on the comparative results in national surveys of patients; or they may (as in the use of the results of the 2010 cancer patient survey at Northbank Hospitals and the setting of benchmarks for the How Are We Doing? survey at Hillside Hospital) be based on managers' decisions about appropriate local comparators. The comparisons that managers make in examining survey results then influence the decisions they make and actions they take in deciding whether and how to use the feedback to improve services. My argument here (as with my argument about the numbers of complaints) is not that these comparisons and decisions are necessarily inappropriate; the argument is simply that these processes have themselves until now not been the subject of empirical investigation. I showed in Chapter 4.5 that there is a lack of clarity about how the standards for improvement in the Quality Strategy at Northbank Hospitals were set. A priority both for service development and for further research is to focus more explicitly and in more detail on the criteria and standards that underpin

the use of patient feedback and other kinds of information to improve the quality of services.

7.2.2 Patient Feedback: the Motivation and Management of Staff

In Chapter 5 I presented detailed evidence about the ways in which feedback from patients is used to manage clinical and non-clinical staff at Hillside and Northbank Hospitals. Although there is a stream of published research examining the effect (or the lack of effect) of feedback from patients on particular behaviours of particular groups of staff, especially doctors, (Jain and Ogden 1999, Cunningham and Dovey 2006, Evans et al. 2007), there has been far less research examining the ways in which feedback is used to influence and manage staff more generally. Only a small number of studies (e.g. Davies and Cleary 2005, Boyer et al. 2006) have reported on the use of feedback to train or support the development of wider groups of clinical and non-clinical staff. The detailed findings I report in Chapter 5 about the ways in which managers use feedback about patients' distress and subjective experience to engage with and motivate staff, about the use of comments, complaints and surveys to train staff, and the use of complaints and survey results to help initiate and monitor substantial changes (in the case of neurosciences at Hillside Hospital) in the staff and staffing of clinical services are essentially new findings. These findings about the use of feedback to motivate and manage staff highlight and begin to fill a significant gap in the patient feedback research literature.

In Chapter 2 I argued that there is a significant gap, relating to the ways in which patient feedback is used to influence and manage the staff who provide health care, in the published research literature. In Chapter 5 I showed that there was little government policy or Department of Health guidance about this issue. One of the aims of this thesis, and of Chapter 5 in particular, has been to help fill this gap. Having collected and analysed a rich variety of readily available data from Hillside and Northbank Hospitals about the use of feedback in the motivation, management and training of staff, I ask why there were these gaps in the literature and guidance. It is almost a truism to say that health care is provided by doctors and nurses and a whole variety of other clinical and non-clinical staff. So, why the lack of attention paid to the impact of feedback on staff? It may be that staff, particularly those who would claim some degree of professional authority and autonomy, are defensive about what they do and the need to change (Bismark et al. 2013; Obermair et al. 2013). Or it may be that the formal goals of policy and the primary focus of the 'improvement' literature (Dixon-Woods et al. 2012, Braithwaite et al. 2014) on health care and the outcomes

of health care, has to some extent shifted attention away from the processes and people through which that health care is produced. If this is the case it further reinforces the case that I made in the previous section for a closer integration in future research of the health care and public service improvement literatures.

One stream of the published research literature about patient feedback (e.g. Jain and Ogden 1999, Cunningham and Dovey 2006) has emphasised the negative emotional and professional responses of doctors to complaints. These studies found that some doctors reacted with hostility to complaints and attempted to limit the access of patients to their services or to withdraw from areas of practice as a result. The findings I reported in Chapter 5.2 about the ways in which feedback about patients' subjective experience of services is used to engage and motivate staff present a different picture. My findings also show that managers can and do deliberately present patients' emotional stress and distress to other members of staff so that the staff themselves feel and understand the nature of patients' experience. Sometimes managers tell the story of patients' distress; sometimes they get the patients themselves to talk directly to staff. These findings extend the argument I developed in Sections 2.3 and 2.4 of Chapter 2 that different kinds of feedback about different domains of patient experience may be used in different ways in the management of services.

The managers who use feedback from patients to influence staff are presumably building on an underlying sense of sympathy or a set of values that mean that the staff will engage positively with the patients' distress and act to prevent or reduce it in the future. This is not to say that this process of engagement is easy for patients, staff or managers; managers talked in interview and gave examples of tears, anger and frustration. But these reactions do not appear to be the same as the antagonism and withdrawal from service that has been reported in the research literature. Perhaps the explanation lies in the difference between feedback by a patient that expresses that patient's distress and feedback in the form of a complaint about the doctor. Or it might be that the processes which managers in clinical and non-clinical roles use to present the difficult or distressing feedback from patients channel the response of staff in particular directions; this process of planned management is unlike the situation of individual doctors who sometimes have to deal with the complaint on their own or only with the support of professional colleagues (Jain and Ogden 1999). If this is the case then it would suggest that it is not only the nature and contents of feedback that influences the eventual outcome but that the

organisational and managerial processes through which it is used themselves have a significant influence on the results.

The research literature (Davies and Cleary 2005, Boyer et al, 2006, Reeves and Seccombe 2008) shows that feedback from patients is used in the training of health service staff. The focus in the published studies tends to be on the use of surveys and other kinds of feedback in 'customer care' training courses for receptionists and other 'front of house' staff. I showed in Chapter 5.3 that Department of Health guidance talks about the use of feedback to support staff 'learning' and improvement; but the guidance does not contain any more detail about how feedback should be used to achieve these aims. My findings from Hillside and Northbank Hospitals provide evidence that feedback is used to support training and staff development in more ways than is reported in the published literature and in more detail than is suggested by government policy. Managers use all kinds of feedback from patients in informal induction of staff in wards and departments, in formal Trust-wide induction schemes, in one-to-one supervision of trainees, in ward and departmental meetings, in customer care courses for receptionists, telephone staff, ward clerks, nurses and others, and in formal in-house training courses about clinical care and the quality of clinical services. These findings identify a considerably wider range of uses of feedback in the training and development of staff than has been previously reported. This widening may be a result of the focus of my study on the use rather than the collection of feedback, of a real increase over the last few years in the ways in which feedback is used in the management of services, or some mixture of the two. The evidence I discussed in the previous section about the increasing interest in the use of feedback to support the safety of services suggests that some at least of the increase has been real.

There is little evidence in the published research literature about the use of patient feedback in the management, as distinct from the training, of staff. At the start of this section I speculated that sensitivities about the implications for staff of patient feedback might have inhibited an explicit focus in policy or Department of Health guidance of the use of feedback in the management of staff. This would be consistent with the findings and views of Cunningham and Wilson (2011) and earlier studies about the negative reactions of doctors to complaints. I presented in Sections 5.3 and 5.5 of Chapter 5 a variety of data about the ways in which patient feedback is used in management of staff. Managers use patient feedback to help set standards of care and behaviour; they make their expectations about those standards clear to the staff whom they manage. Senior managers use formal performance review systems to

hold managers and staff to account for the results and use of patient feedback. Managers use feedback in a variety of ways in managing individual members of staff: they speak to them 'addressing issues' in private; feedback is used in professional portfolios and annual reviews; it is used in performance management and disciplinary proceedings with staff, leading sometimes to staff being moved between posts within a Trust or dismissed from employment. Managers use feedback to support changes in the staffing structures and skill mix and in the management structures of wards and services. In all of these ways my findings add breadth and detail to the published research literature.

But at the same time the depth and detail of my evidence about the use of feedback in the management of staff is not complete. Managers in interview said that feedback was used in the performance management of staff and that it had led to disciplinary action. They did not offer and I did not press in interviews for more detail about specific examples. Meetings in public of Boards of Directors and public papers produced by Trusts do not describe the use of feedback to manage staff. The management of individual staff is an issue that is dealt with and discussed in private. My lack of detailed data to corroborate the more general statements in interviews is a limitation of this research. This limitation does not in itself undermine the validity of my findings and their contribution to filling the gap in the published literature, but it does point towards the need for further research that gains access to some of the more sensitive and private issues – the management of individual members of staff – in the management of the NHS and other public services.

Government policy, as expressed in the NHS Constitution, is that Health Service staff should welcome feedback from patients, learn from mistakes and build on successes. The Constitution tends to assume that staff are positively motivated to use feedback to improve services for patients, but Department of Health guidance says nothing about how that motivation is developed or sustained. The published research literature I reviewed in Chapter 2 provides no evidence about how patient feedback in general, or positive feedback in particular, is used by managers to influence the motivation and morale of Health Service staff. Formal and informal patient feedback is used by doctors and nurses in their professional portfolios and is the subject of discussion in annual performance reviews and plans for professional development. These developments are taking place alongside more recent formal requirements for the use of feedback in professional re-validation (General Medical Council 2012). The findings I presented in Chapter 5.4 show that managers use a variety of different kinds of feedback – thank you letters and cards, reductions in the

numbers of complaints, the results of surveys of patients, nominations in staff commendation schemes – simply to thank staff for their work, to praise them for their contributions to the care of patients, and to support their morale. Despite the lack of attention in the research literature and policy guidance, the use of positive feedback to support and influence staff is a significant part of the managerial processes that are being developed in the Health Service. My findings, however, then raise the question of how this use of positive feedback to thank and motivate staff relates to the use of feedback to improve the quality and standards of service.

I argued in Chapter 2 that the research literature identifies the aims of using feedback from patients as being in broad terms to improve health care or to improve the quality of health services, but that the published literature contains little explicit analysis of the criteria and standards by which improvement is judged. I showed in Chapter 5.4 that managers use feedback from patients to praise staff for their contributions to care and the quality of services. This praise itself implies that managers have explicit or implicit standards by which they judge the quality of services. My findings also show that managers themselves respond positively to positive feedback about the services for which they are responsible. These responses might also show that managers have implicit standards by which they judge the quality of services; they are pleased when the feedback shows they are achieving these standards. If this is the case, my findings in Chapter 5.4 that managers do not explicitly and directly use positive feedback from patients to help identify quality standards is perhaps surprising. But there is also another possible interpretation: managers are pleased and praise staff not because certain quality standards have been achieved, but simply because the feedback from patients itself is positive. In this interpretation managers use feedback to praise staff not because the standards of care are high but because patients are pleased or satisfied. This distinction links directly to the definition of Boyne (2003) of ‘public service improvement’ as a narrowing of the gap between expectations and performance, and points, as I discuss in the last section of this thesis towards the need for further research to identify and describe the criteria and standards of improvement that are actually used in the management of health services.

7.2.3 Organisational Processes in the Use of Patient Feedback: Boards of Directors

Recent research studies and commentaries (e.g. Levinson and Shojania 2011, Giles et al 2013, McDonald et al. 2013) have argued that feedback from patients

can and should be used to help assure the safety and quality of services. Government policy and regulatory requirements in England place responsibility for assuring the quality of hospital services on the boards of directors of NHS trusts and require them (as I have shown in Chapter 6) to use feedback from patients to help assess the quality of services. None of the patient feedback research literature that I reviewed in Chapter 2 examines the ways in which boards of directors in the NHS use patient feedback to help assess and assure the quality of services. The evidence about the Boards of Directors at Hillside and Northbank Hospitals that I presented in Chapter 6 showed that both Boards received and discussed a variety of feedback from patients. The ways in which the Boards used this feedback could be interpreted as a form of quality assurance, but the agendas, papers, discussions and minutes of Board meetings in public did not explicitly use the word 'assurance'. Managers in interviews talking about the use of feedback occasionally mentioned assurance, but did not link it with the role of Boards. The papers and minutes of committees reporting in public to the Boards were not worded in terms of quality assurance. The conclusion to be drawn from this evidence is that if Boards of Directors do use feedback from patients to help assure the quality of services, then either this takes place in private meetings or it is an implicit rather than an explicit function. Either way, these findings raise issues about the role of Boards that deserve further investigation.

The Mid Staffordshire Hospitals scandal of the mid 2000s gave a substantial impetus to the development of government policy and regulatory control of the Health Service. I showed in Chapter 4.3 how the scandal influenced the 2010 Regulated Activities Regulations and in Chapter 6.2 how the 2010 Francis Report led to the Chief Executive of the NHS asking all organisations to review the quality of their services and their organisational arrangements for quality assurance. I also showed in Chapter 6.2 how the two Trusts at Northbank and Hillside Hospitals responded differently to these events, Northbank by undertaking a comprehensive review of its patient involvement mechanisms and then developing a quality strategy, and Hillside by bringing detailed reports based on its existing patient feedback mechanisms to each meeting of the Board of Directors. Something of the original reasons why I selected the two Trusts for this study – Hillside because of its reputation for the How Are We Doing? survey; Northbank for patient and public involvement in the development of services – appears to be reflected in these different responses. The responses thus appear to reflect different institutional histories and trajectories in the two Trusts, indicating that further research on patient feedback should focus not only on specific actions but also (as is suggested by the findings of e.g. Reeves and Seccombe 2008)

on the influence of organisational context on the ways in which the feedback is discussed and used within Trusts

I argued in Chapter 2 that the patient feedback research literature (e.g. Tasa et al.1996) identifies the development of Trust strategies and plans as one of the uses of patient feedback. But with the exception of Davies et al. (2008) the literature contains little detail about how feedback is used to support the development of strategies and none about its use in the implementation and monitoring of strategies. Although legislation, government policy and the regulatory bodies say that NHS organisations should use feedback from patients to improve the quality of services, and this then could be taken as implying the Trusts should use feedback to support the development of their service strategies and annual plans, this is not explicitly stated in the Department of Health policy documents and guidance. The evidence I have presented in Chapter 6.2 shows that Trusts do, to some extent, use feedback in the development of their quality strategies and plans. The evidence for this is much stronger in the case of the development in 2011 of the Quality Strategy at Northbank Hospitals than it is in the case of the annual planning cycle at Hillside. At Northbank managers analysed a large swathe of feedback from patients to help produce a long list of potential priorities for improvement. They involved patients and staff in discussions to identify the highest priorities that then formed the basis for their strategy. But I also showed that, despite the formal agreement of the Board that patient feedback should be used to monitor progress with the strategy, there were no reports containing this information to the Board in the following 18 months. The evidence demonstrates how important it is that we should not simply assume that feedback from patients is used to improve services but that we think carefully about the different uses to which feedback may be put and then study empirically how it is actually used.

Although these findings are consistent with the lack of evidence in the published research literature about the use of feedback in the monitoring of strategies, they also do suggest that it is not simply a lack of evidence that is the issue here. It appears rather to be a matter of fact that Trusts do not in practice use patient feedback to guide and monitor at the broadest level the implementation of their strategies. If this is indeed the case, it may be (as with the use of feedback to help monitor the safety of services) another development issue that will be addressed as practical experience in the use of feedback increases. Or it may be a broader issue reflecting the greater priority given by Boards and senior managers to establishing, within the requirements of government targets and regulatory requirements, the strategic

direction and priorities of Trusts than to ensuring that the strategies are appropriately monitored and effectively implemented.

Although there is an increasing research literature (e.g. Baraitser et al. 2008, Giles et al. 2013, McDonald et al. 2013) on the use of feedback from patients to help assess the quality of services and to identify and rectify problems in quality, none of the empirical literature I reviewed in Chapter 2 focuses explicitly on the use of patient feedback in quality assurance. The focus in the published research has been on the identification and resolution of specific problems as distinct from the organisational procedures through which quality standards are assessed and the quality of services maintained. I showed in Chapter 4.3 how the 2010 Regulated Activities Regulations legally require all providers of health care to seek the views of service users in order to come to an informed view about the standard of care and treatment provided. The issue I examined in Chapter 6 relates to the procedures that Trusts use to make use of feedback from patients to come to an informed view about the standard of care. The detailed findings I reported in Chapter 6.3 showed that, although Boards of Directors of Trusts do receive and discuss a variety of information based on patient feedback, including the Patient Experience Report at Hillside Hospital, they did not formally describe this, either in the Board papers or in interview, as quality assurance. I also found no direct evidence in the agendas, papers and minutes of Board meetings that Boards received reports from their Committees that explicitly showed the feedback from patients was examined and assessed as part of a formal quality assurance process. This absence of evidence is of itself not conclusive evidence that the Boards did not use patient feedback for quality assurance. But, as with the example of the lack of use of patient feedback in the monitoring and implementation of the Trusts' strategies, it is suggestive. If the use of patient feedback within quality assurance procedures is not explicit, then the accountability of Trusts to the public for the quality of their services cannot be examined and tested against any empirical evidence. The public itself is not assured of the quality of services. It can be argued, at the very least, that if Trusts and their managers were more explicit and systematic about the place of patient feedback in quality assurance, and about the role of the Boards themselves, Committees and their sub-committees, then they might find gaps or inconsistencies in their activities that could then be addressed and eliminated. This, as with so much else to do with the use of patient feedback, is an issue in which future research and service development would potentially go hand in hand.

My evidence and analysis in Sections 6.2 and 6.3 of Chapter 6 raised the question: if Boards of Directors do not use feedback from patients to monitor and

support the implementation of their strategies or explicitly to assure the quality of services, what do they use it for? The research literature I reviewed in Chapter 2 (Davies and Cleary 2005, Boyer et al 2006, Davies et al. 2008) showed that Boards of Directors often received and considered reports about patient feedback; but the reports of these studies did not identify the decisions made by the Boards or the actions that followed their discussions. The evidence I presented in Section 6.4 begins to answer some of these questions, but not it must be said with any great clarity. My observation of Board meetings and the minutes of the meetings provided evidence of a lot of discussion of patient feedback. The discussion at Northbank Hospitals was in 2011 part of the development of the out-patient improvement initiative and of the Trust's Quality Strategy. The discussion at Hillside was often based on the Patient Experience Report, but was not focused on any particular objectives, developments or decisions. The evidence from interviews suggested that feedback was used by the Hillside Board to feed into annual plans and Quality Accounts; it helped set the context for decisions and priorities of the Board. This lack of detail and lack of clarity is consistent with the findings in the earlier research papers. It may reflect the fact that the Boards themselves are not clear or, alternatively, it may reflect the fact that they often do not use feedback for any clear purpose. Paradoxically, the Board that received the most detailed regular reports of patient feedback made the least explicit use of them. Perhaps receiving and discussing patient feedback gave the Hillside Board a sense that they were using it effectively in their discussions; perhaps the absence of regular reports at Northbank and specific pressures around the quality of services prompted Executive Directors and the Board at Northbank to use feedback explicitly to develop their strategy.

This interpretation would also be consistent with the analysis I suggested above that the Board at Northbank did not itself continue to make use of the available feedback once it had agreed its Quality Strategy. The sense of assurance that Boards receive from having a strategy and from discussing feedback may mean that they then do not continue, in the face of many other pressures and priorities, to continue in detail to assess progress and make specific decisions using that feedback. At the very least, the lack of clarity about the continuing use of feedback by both Boards raises questions about the accountability of boards of directors of NHS foundation trusts to their patients and the public and about the assurance that they provide to the public about the use of patient feedback and the quality of services.

7.2.4 The Uses of Patient Feedback: Towards a Synthesis

I started the literature review in Chapter 2 by summarising the ground-breaking study of Tasa et al. (1996) based in one hospital in the USA. Theirs was the only study I have identified that has attempted to list and describe the different uses of patient feedback in hospitals. My evidence more than 15 years later from two hospitals in the NHS in England reveals some similarities with and some differences from their findings. I found (to greater or lesser extent) in Hillside and Northbank Hospitals most of the uses of feedback that had been reported by Tasa et al.: dissemination of the results of feedback; strategic and annual planning; identifying broad issues and priorities; responding to immediate problems. I did not find examples corresponding to their use 'selecting quality improvement teams'; and I found only limited examples of monitoring progress. Similarly I did not find examples of some of the uses of feedback I had listed in Chapter 2.6 drawing on other published research studies: changing services to reduce risks and the practice of defensive medicine; providing information to referrers and other external bodies. But I did find substantial evidence and numerous examples of other uses of feedback in the two Trusts: setting the tone of the Trust and forming the context for planning decisions; supporting and publicising good practice in clinical care and the quality of services. My most substantial range of new findings however relate to the use of feedback in the motivation and management of staff: both in the use of positive feedback to support and praise staff, in the use of feedback about patients' subjective experience to engage with and motivate staff; and in the use of complaints and negative feedback to inform the training and formal management of staff.

The findings about the use of feedback to influence staff are important in analytical and practical terms; staff are the medium through which services are produced and delivered; in terms of the input, process output model of service improvement (Talbot 2010, Boyne et al. 2010) I reviewed in Chapter 2.5 they are an integral part of the production process. More generally, the fact that empirical research is continuing to identify and describe additional uses of patient feedback suggests that new uses may be emerging in practice at different times and different places, as new technologies to collect feedback and new ideas about the provision and management of services are put into practice. Although there would be practical benefit in the collation and dissemination of examples of good practice, there is also a need for continued research to describe, and then to evaluate, the new uses of feedback that do emerge.

In Chapter 2 I reviewed a wide range of research literature about different kinds of patient feedback, about the domains of patient feedback and about the uses of patient feedback. One reading of that literature might suggest that surveys of all kinds may be used for benchmarking and performance management of trusts and of individual services within trusts. Individual patients' stories, complaints and in-depth feedback through focus groups may be used for the more detailed analysis of problems and as the starting point for planning and designing service improvements. Coulter et al. (2009) suggested that detailed qualitative methods of collecting feedback are best suited only for local analysis, service improvement and monitoring, but that quantitative surveys and routine statistics are used not only for local analysis and improvement but also for benchmarking and comparisons and for communicating with and accountability to external stakeholders and the public. The evidence from Hillside and Northbank Hospitals I have presented in Chapters 4, 5 and 6 in some ways supports this analysis but in other ways undermines the analytical framework on which it is based.

Much of the evidence I have presented in this thesis supports the view that qualitative feedback is best used locally for improvement and that quantitative feedback is also used for comparisons, benchmarking and accountability. Chapters 4 and 5 contained detailed examples of the ways in which patients' complaints and the accounts and stories of individual patients about their experience in hospital are used to engage and motivate staff and to prompt improvements in specific services. Chapter 4 also described the use of detailed feedback generated through patient focus groups to support the redesign and development of the chemotherapy day unit at Northbank Hospitals. Much of my analysis in Section 4.5 focused on the ways in which the quantified scores resulting from surveys of patients are used in the establishment and monitoring of CQUIN targets at both Hillside and Northbank Hospital and, in the case of Hillside Hospital, of standards and benchmarks for the management of service in the Trust as a whole and within each of the clinical divisions. I also showed in Section 5.5 how patients' complaints, survey data and other local data were used together in the management of staff and improvement of the neuroscience services at Hillside Hospital. All these examples support the analysis that qualitative feedback is used to support local improvement, but that results of surveys are also used for benchmarking and standard setting.

But the relationship is not simple or direct. Further examples suggest that detailed qualitative data (as well as quantitative data) are also on occasion used for comparative purposes in the management of Trusts and as part of the public

accountability of Trusts. I gave the example in Section 5.3 of how managers compared individual complaints about the quality of care in particular wards at Northbank Hospitals with complaints from other hospitals described in the Health Service Commissioner's report. In Section 6.4 I gave examples of the way in which the Chief Executive's Report at Hillside Hospital explicitly put into the public domain examples of feedback from individual patients; one example praising the quality of care provided at the Hospital, the other critical of it. And in Chapter 6 I also showed how the Boards of both Trusts, received in their public meetings some information based on individual patients' stories or complaints. Although the evidence is suggestive rather than conclusive it does indicate that qualitative feedback may be used for analysis, reporting and accounting in ways that have not been explicitly identified in the previous research literature and reviews.

More fundamentally the evidence presented in this thesis casts doubt on the proposition that an examination of the relationships between different kinds of feedback and different uses of feedback is the best way to proceed. It is partly that the distinction between qualitative and quantitative feedback is not the only important distinction to be drawn. A substantial part of my argument in Chapter 4 has been that the distinction between patients' subjective experience of services and what they say about the services themselves is of crucial importance for understanding how feedback is used. Managers use patients' subjective experience in different ways and for different purposes – to influence and motivate staff, as I showed in Chapter 5 – than they use feedback about services. A further part of the argument is that the isolation of patient feedback as a specific phenomenon that may be used in particular ways is not the most useful way of examining how feedback is used or why it is used in particular ways. The detailed examples I presented, in Section 4.6 about the use of patient surveys in the cancer services at Northbank Hospitals and the food service initiative at Hillside Hospital, in Section 5.5. about neurosciences at Hillside Hospital, and in 6.5 about the out-patient improvement initiative at Northbank Hospitals, all demonstrate that the way patient feedback is used in the management of hospitals is itself a complex organisational process. Feedback sits alongside a wide variety of other kinds of information; its use (as has been reported in other research studies e.g. Davies and Cleary 2005, Reeves and Seccombe 2008, Brown et al. 2009) is subject to a wide variety of organisational pressures. The implication is that any future frameworks for examining the use of patient feedback should focus not on a simple cross-tabulation of different kinds and different uses of feedback, but instead on a more careful analytical approach that tracks on a chronological basis all the

organisational processes that contribute to collection, receipt, analysis, decision-making and use of feedback in specific policy and institutional settings.

Beyond this kind of analysis, however, is evidence from my findings about quite fundamental variations, and possibly inconsistencies, in the way in which feedback from patients is perceived and used in the management of staff and services in hospitals. On the one hand clinical and service managers emphasise the subjective nature of patient experience, the stress and distress experienced by patients. Some managers and directors take explicit steps to expose themselves to this kind of feedback. They use feedback about patients' feelings to engage with and motivate staff, so that the staff themselves work to improve the quality of the health care and the services they provide. At the same time the formal reporting and management systems of Trusts rely heavily on the quantified results of surveys of patients. These surveys are usually, but not necessarily, about patients' perceptions of the care they have received rather than about their own feelings and emotions. The results and reporting of the surveys then take on for some managers a significance of their own. Achieving benchmarks and targets, seeing scorecards that are coloured green rather than amber or red, themselves are causes of pleasure for managers.

The irony here is that the scorecards and benchmarks are not always used within Trusts by Boards of Directors or other managers with the systematic rigour that management theory and the advocates of target setting and performance management might consider appropriate. Managers say that they will use feedback from patients to monitor strategies and provide assurance about the quality of services; but they do not then explicitly do so. My evidence suggests that managers in Trusts collect and use feedback from patients to improve services, not in ways that are fully thought out and based on a single conceptual model but in ways that are partly intuitive and partly informed by organisational custom and practice. The task for further research, if this analysis is correct, is therefore not simply to map and describe the different uses of patient feedback but also to identify and analyse the beliefs and institutional practices on which it is based.

7.3 Conclusions

In Section 7.2 I discussed the findings of my research in the context of the published research literature about patient feedback and began to identify out the implications for future research. In this section I draw these strands together, summarising the contributions of my research to our knowledge about the use of patient feedback in the management of health services and identifying the

implications of this study for the development of policy and practice in health services and for the direction of future research.

7.3.1 Contributions to Knowledge

This research has contributed to our knowledge about the use of patient feedback in the management of hospitals in three main ways: our understanding of the different kinds of improvement in services to which feedback contributes; our knowledge of the use of feedback to influence and manage staff; and our knowledge of the use of feedback to help assure the quality of services and for other purposes by the boards of directors of NHS trusts.

Many authors of research papers and reviews (e.g. Reeves and Seccombe 2008, Jonsson and Ovretveit 2008, Patel et al. 2009, Raleigh et al, 2009, 2012, Rozenblum et al. 2013) have assumed or stated that the primary purpose of collecting feedback from patients is to improve health care or health services. These authors have not explicitly examined the different aspects of services may be improved by the feedback; nor have they analysed the criteria and standards by which improvement may be assessed. My research extends and deepens our knowledge about the use of feedback to improve services in three main ways. First, my research has shown for the first time that feedback about patients' subjective experience of their illness and their health care and feedback about the services themselves are used in different ways. Feedback about patients' subjective experience is used by managers to engage and motivate clinical and non-clinical staff; feedback about services is used more directly to improve the quality or delivery of those services. Second, the research has shown for the first time how the questions included in surveys of patients (and to a lesser extent the issues raised by patients in qualitative feedback) are used to establish the criteria by which the quality of services is assessed. It has shown how the numerical scores derived from the results of surveys are used to establish benchmarks and standards against which services are judged and the time trends by which improvement or deterioration is judged. Third, the research has shown that these standards relate not so much to patients' subjective experience as to the characteristics of services themselves; managers use feedback from patients to support the improvement of services against criteria and standards that are defined by policy makers and service providers rather than by patients themselves.

Each of these three sets of findings about the use of feedback adds to the empirical research literature; they are new findings. But, taken together, they are more than this: they also open up new lines of enquiry about the relationships between

different kinds of patient feedback and the different ways in which feedback is used in the management of services. The argument emerging from these findings is that, although the subjective aspects of patient feedback are used individually and powerfully by managers to motivate staff, the formal management systems of Trusts incorporate only structured feedback about the services themselves. There is a disjunction and possible inconsistency between these different components of management practice. Although this disjunction may originally have arisen from differences of perspective between clinical professions interacting with individual patients and general managers focusing on quantified targets and performance indicators, the evidence I have presented in this thesis showing that general managers as well as clinical managers seek and use feedback about patients' feelings and subjective experience suggests that management systems may need to be developed to take more account of feedback about individual patients' feelings. Public management theory may need to be developed to incorporate the ways in which managers use individual and subjective feedback alongside more traditional performance targets and measures.

A small number of empirical research papers (e.g. Davies and Cleary 2005, Boyer et al. 2006) have reported that patient feedback is used to support the training or general development of staff in health services; others (e.g. Greco et al. 2001, Evans et al. 2007) have reported the results of trials of providing doctors with the results of feedback from patients in an attempt to change the doctors' behaviour in clinical consultations. None of these studies have examined the ways in which feedback is used to influence and manage clinical and non-clinical staff in hospitals more generally. The present study has begun to fill this gap in the literature and has reported new findings about the ways in which managers use feedback from patients to influence and manage clinical and non-clinical staff in hospitals. It has shown that managers use feedback about patients' subjective experience – their stress and distress – to engage with staff and motivate them to improve the quality of care they provide. Patient feedback is used not only in the training of staff but also in more formal management processes. It is used by clinical staff as part of their professional portfolios that are reviewed regularly by their managers. It is used by managers in formal processes that may result in staff being moved from their current posts or leaving their current employment. Positive feedback is used frequently and regularly, in informal settings and in staff commendation schemes, to praise staff and to thank them for their work contributing to the care of patients. These are new findings that have not previously been reported in the research literature; they demonstrate the

variety and complexity of the ways in which feedback from patients is used to influence and manage clinical and non-clinical staff in hospitals.

My findings about the ways in which the use of patient feedback are used by managers to influence and manage clinical and non-clinical staff in hospitals are not only new findings that begin to fill a gap in the patient feedback research literature. They also point towards ways in which different empirical and theoretical themes should be brought together. The empirical patient feedback research literature on which I have drawn throughout this thesis does not itself draw on wider theory or research about the motivation of managers or staff. The argument from evidence I have presented here is that clinical managers, non-clinical managers and other staff identify with and are motivated by patients' own experience and that this motivation then influences the ways in which they use feedback to improve the quality of services. A better understanding of these processes is likely to come from empirical studies that draw more explicitly on organisational psychology and human resource literatures as suggested by for example Hoggett (2006) and Fisher and Byrne (2012).

Legislation, government policy and the requirements of regulatory bodies impose duties on the boards of directors of NHS trusts to collect and use feedback from patients to help them assess and assure the quality of the services they provide. Although recent research studies and commentaries (e.g. Levinson and Shojania 2011, Giles et al 2013, McDonald et al. 2013) have argued that feedback from patients can and should be used to help assure the safety and quality of services, none of the empirical research studies reviewed in this thesis examine the role of boards of directors in the use of patient feedback to assure the quality of services or for other purposes. This is a significant gap in the research literature that the present research has begun to fill. This study has shown that the Boards of Directors at Hillside and Northbank Hospitals responded to the Francis Report on the Mid Staffordshire Hospitals in 2010 by reviewing and to different degrees changing the ways in which they received and considered feedback from patients. It has shown that, although the Boards have established committees to help provide assurance about the quality of services, it is not clear that the committees actually provide the Boards with evidence that they have used patient feedback explicitly for this purpose. It has also shown that although the Boards at both Hillside and Northbank Hospitals consider patient feedback as it relates to CQUIN targets and regulatory requirements, the Board at Hillside Hospital also considers and discusses feedback more frequently and in more depth than does the Board at Northbank. Although managers at Hillside say in interview that the purpose and effect of these discussions is to condition the Board in

their view of the Trust and its priorities, there is very little direct evidence from the meetings in public of the Board as to whether and how this happens. The finding from this research is therefore that Boards do receive and discuss feedback from patients, but that it is not clear that they do actually use it for quality assurance or for any other specific purpose. These are new findings that have not previously been reported in the research literature; they suggest a need for further research in this area to identify more clearly the true lines of reporting and accountability in the use of patient feedback to Boards and from Boards to patients and the public.

7.3.2 Implications for Policy and Practice

In the Introduction to this thesis I highlighted the fact that policy and practice in the Health Service in England have, alongside research and academic commentaries, focused far more on the collection of feedback from patients than on the use of this feedback in the provision of health care and the management of services. Although there is some evidence that this focus is changing (NHS Institute 2013) the focus on the collection of feedback rather than the use of feedback is as true of the Friends and Family Test introduced in 2013 as it is of earlier policy initiatives about different ways of collecting patient feedback. This thesis has examined the ways in which patient feedback is actually used in the management of hospitals in the NHS in England; it has shown that feedback is used in a variety of complex ways to support good practice among staff and promote improvements. Focusing on the ways in which feedback is used is not, of course, to argue that it is always used in these ways or that it is used as effectively as it could be. My findings about the ways in which information about patients' experience is superseded by measurements derived from operational systems in the management and monitoring of improvement initiatives, and my findings about the lack of clarity in the ways in which Boards of Directors use feedback to help assure the quality and safety of services, show at the very least that there is scope for review and improvement in the ways in which patient feedback is used in the management of services. The first, very general, practical implication of this research that policy makers, service improvement agencies and the managers of health services should in future pay at least as much attention in their everyday work to the use as to the collection of patient feedback.

One of the main themes of this thesis has been to do with the way in which feedback from patients is used to 'improve' health care and health services. I have argued that there is, among policy makers, practitioners and managers, a lack of clarity and systematic analysis of what is meant by improvement. Policy makers and

managers are often, again like some authors of empirical research papers about patient feedback, not clear about the criteria and standards that are used to judge improvement in the quality of services. This lack of clarity is as apparent in the NHS Feedback Challenge initiative (NHS Institute for Innovation and Improvement 2013) and the Friends and Family Test introduced in 2013 as in earlier real-time feedback initiatives. It appears sometimes to have the consequence that 'improvement' is little more than a convenient rhetorical label – 'improvement' is always desirable – that then allows managers to focus on other issues.

The second practical implication of my research is that policy makers and managers could usefully pay more attention to the criteria and standards of the quality of services to which feedback from patients and other kinds of information contribute. This is not to argue that policy-makers and managers should at this point in time try to establish explicit or quantified standards based on feedback from patients. The issues are more complicated than that. The first step is to go back, behind the 'patient experience' phrases of the Darzi Report (Department of Health 2008b), following the analytical lead given by Entwistle et al. (2012) and the distinction I have drawn in this thesis between feedback about patients' subjective experience and feedback directly about services, to develop a more systematic and detailed analysis of the different ways in which patient experience and health care can be improved. The next step is then, while paying attention to the fact that different people – policy makers, managers, clinical practitioners and managers – may all have different views about what constitutes improvement and about the relative importance of different aspects of improvement, to examine the relationships between different aspects of improvement. The aim is to examine whether the different criteria and standards of improvement, for example the cleanliness of hospital wards, the attitudes and behaviour of staff, and the relief of pain, are of equal importance to each other as is implied in the format of balanced scorecards, or whether the domains of patient experience and service provision have different degrees of importance in different circumstances. The challenges in this programme of work mean that it should not be visualised by policy-makers or managers as an exercise in setting standards or performance management; it instead requires a developmental approach to service improvement, in which ideas and proposals are discussed interactively and on a continuing basis by all the stakeholders, patients and service providers alike.

One of the main contributions of this research has been to identify and describe the use of patient feedback by managers to influence and manage clinical and non-clinical staff in hospitals. There is, despite the central importance of staff in

the provision of health care and health services, very little government policy or guidance from the Department of Health or regulatory bodies for NHS organisations on this issue. My research has shown that managers use both negative and positive feedback from patients in a variety of ways in hospitals, to engage with and motivate staff to improve services, to praise and thank them for their work in providing high quality care, and support more formal processes of annual review and performance management of individuals. It is of interest, in this context, to note that managers at Hillside and Northbank Hospitals did not use positive feedback from patients to try explicitly to establish standards of high quality services or improvement; they used thank you letters and commendations more simply to thank and praise staff for their work. Given the lack of established procedures in the use of feedback in the management of staff, and more especially the lack of knowledge about the effects and effectiveness of different ways of doing things, the practical implication of my research is, again, that initiatives by policy makers and managers should focus not on trying to establish policy or standards in this area but on sharing examples of using feedback in this way and sharing lessons about what works and what does not work. They should focus on the identification and development of good practice.

I showed in Chapter 6 that, unlike in many other areas relating to the use of patient feedback, there is quite explicit legislation, government policy and regulatory guidance in the wake of the Mid Staffordshire Hospitals scandal about the use of feedback from patients to help assure the safety and quality of services. Boards of directors of NHS trusts and NHS foundation trusts are responsible for the services their trust provides and for assuring the quality of those services. My findings in Chapter 6 demonstrate that it is not always clear how boards of directors discharge these responsibilities. It is not always clear how the boards use feedback from patients to help assess and assure the safety and quality of the services they provide for patients. The immediate practical implication of these findings is the boards of directors should commission independent and impartial audits of their compliance with the regulations and, more generally, of their use of feedback from patients in the assessment and assurance of the safety and quality of services. The results of these audits, should in keeping with the recommendations of the Francis Reports of 2010 and 2013 be made public. The findings I reported in Chapter 6 about the ways in which Boards pay less attention than they originally intended to follow-up action and monitoring the effects of their initiatives also imply that boards should be expected to review systematically and in depth the results of the actions they have taken as a

result of the original audit. The first step towards improvement is a rigorous audit of current practice.

7.3.3 Scope and Limitations of the Research

The research I have presented in this thesis is a study of the use of patient feedback in the management of hospitals in the NHS in England. The nature of the study defines much of the scope and some of the limitations of the research. The study started with a topic to be investigated, rather than a set of hypotheses to be tested. The topic itself – the ‘use’ of patient feedback – was not clearly defined. The word ‘use’ in everyday language has a very broad meaning, something to do with the actions that people take with a particular tool or implement. In this study I have not attempted to define how feedback is ‘used’ more precisely; instead I have focused on identifying and describing some of the different ways in which it is used. As a result of my analysis, I have shown that feedback is used in many different ways in the management of hospitals. I have described uses of patient feedback that have not previously been reported in the research literature. The strength of approach is that it discovers and describes things that were previously unknown; the limitation is that it does not provide a comprehensive or systematic analysis of all the questions that might be asked about those phenomena.

The research design that I have used in this study, as with any particular design, also has implications for the scope and limitations of the research. I have undertaken a qualitative investigation in a small number of organisational settings. The qualitative investigation is appropriate to a study, where specific issues and research questions are not clearly formulated at the start of the investigation. It encourages the identification and selection of particular topics for detailed examination both during fieldwork and during data analysis. It allows one to return to the field or to documentary sources to collect additional data for further analysis of issues. It therefore encourages the analysis in depth of particular examples of the objects being studied; in this study I have built up from a variety of sources chronological and analytical accounts of specific examples of the use of patient feedback. The building up of these analyses and explanations is the strength of qualitative research; but at the same time it is a limitation. It means that less attention is paid that might otherwise have been the case to the full range of examples of the phenomena that are being studied or to the definition and classification of all the different examples and the relationships between them. The analyses of different kinds, domains and uses of patient feedback that are inherent in the coding frame in

Appendix 6 demonstrate the potential that existed for focusing my research in this study on the systematic classification of different kinds and uses of patient feedback; this then might have led the research in the direction of producing a large scale, systematic cross-tabulation of the different kinds, domains and uses of patient feedback. Instead, during both data collection and data analysis I focused on the detailed examination and analysis of specific examples of the use of feedback, with the intention of describing a small number of specific issues in depth rather a larger number of issues more superficially.

The data I collected for this study included legislation and government policy documents but fieldwork was restricted to two foundation trusts in the NHS in England. I selected these Trusts because they both had reputations for collecting and using different kinds of feedback from patients in different ways. Within each Trust, I selected particular issues and services for detailed investigation because initial observation showed and early interviewees said that these were areas where feedback from patients had been used significantly in the management of services. The specific focus of data collection in this way has been a strength of the study and at the same time imposes significant limitations. The strength, as I have already suggested, has been the ability to build up and analyse in depth and in detail information about how patient feedback is collected and used in specific circumstances. These descriptions and analyses constitute the new knowledge generated by the research. The limitations lie in the fact that the findings of the study may not be representative of other events inside the two NHS Trusts, of other hospitals and other organisations in the NHS, or of other health services in other countries. It is then a task for subsequent research to take the findings and knowledge generated here and test how far they hold true in other settings and other circumstances.

The main fieldwork and data collection for this research was undertaken in 2011. The findings therefore relate not only to two selected NHS foundation trusts but to those Trusts at a particular point in time. Although there have been significant changes to the structure of the NHS with the introduction of clinical commissioning groups in April 2013, the regulatory framework overseen by Monitor and the Care Quality Commission and the national contractual framework for acute hospital services that together establish the terms on which NHS foundation trusts provide services remain in place. Although specific policies and priorities change, and will undoubtedly continue to change, it can be argued that the structural continuities

relating to NHS foundation trusts mean that the findings from my fieldwork in 2011 continue to be relevant in 2015.

Government policy and NHS practice about the collection and use of patient feedback have to some extent developed since 2011. One of the main developments has been the introduction and extension of the Friends and Family Test, patients being asked if they would recommend a particular service or department to their friends and family if they had a similar condition. The Test was introduced into acute hospitals in 2013, general practice in 2014 and a wide range of other services in 2015. The emphasis to date has been on the introduction of the Test. It again raises the question that was the starting point of this research; how are the results of the survey actually being used in the management of services. Many hospital wards and departments now display the results of the survey on notice boards for patients, visitors and staff to see: '92% of patients say they would recommend this ward to their friends and family' is a recent example that I have seen. At the same time and on the same notice boards wards and departments provide short examples of feedback in a 'You said ... We did ...' format. This anecdotal information suggests that the attention of service providers and managers may now be focusing more closely on the use of feedback; but it also raises as a question for further research whether the examples that are chosen are primarily for display or whether the new kinds of feedback are now also being used more substantially in the redesign and transformation of services.

The nature of my research and the selective processes in data collection and data analysis mean that the substantive findings presented in this thesis relate to specific topics of interest in the collection and use of feedback from patients, but not to others that might also have been of interest. This process of selection is integral to and unavoidable in qualitative research. My focus here has been on three main topics: the use of feedback to improve services, and questions of how improvement is defined and measured; the use of feedback to influence and manage the clinical and non-clinical staff who provide services for patients; and the use of feedback by boards of directors who are responsible for the health care and services provided for patients. In this thesis I have generated and presented new knowledge about the use of patient feedback in each of these three areas. But, alternatively, I might have focused the data collection and analysis more closely on other topics that could have been of significant interest: the collection and use of new forms of feedback from the internet and social media; the use of feedback about clinical diagnosis and treatment and its relationship with patient-reported outcome measures; the use of feedback in

the general management and performance management of individual services and departments within the Trusts; the use of feedback in setting CQUIN targets and agreeing contracts between commissioners and NHS trusts and in the monitoring of those contracts. In each of these areas it might have been possible to generate new findings and new knowledge; they remain at present topics for further investigation.

The research I have presented in this thesis has been explicitly empirical in focus. The research started from a substantial gap in the patient feedback empirical research literature – the lack of in depth and systematic research describing the uses to which feedback from patients is put in the management of hospitals in the NHS in England. My research has begun to fill this gap with substantial new empirical data and, as I suggested in the last paragraph and will develop in the next section, points towards further research that will help fill the gap more widely and systematically. But, although I drew in Chapter 2 on the public service improvement literature in order to help develop ideas about the ways in which patient feedback might be used to improve services, the research presented in this thesis has not drawn on explicit theoretical frameworks in public management or organisation theory more generally. This empirical focus reflects much of the patient feedback research literature I reviewed in Chapter 2; that literature, reflecting in part the interests of clinical researchers and applied health services research more generally, is more concerned to generate robust knowledge about the delivery and effectiveness of health care than to develop or test social or sociological theory more generally. Within this tradition I have focused this thesis on the generation of new knowledge about the use of feedback from patients in the management of NHS trusts. In the next section, on directions for future research, I will point towards some of the connections that might usefully be made with theory.

7.3.4 Directions for Future Research

This research has opened up a wide range of possibilities for further investigation, some empirical, others more theoretical in orientation.

As I suggested in the last section, the fact that this thesis has focused on a limited number of specific aspects of the use of patient feedback – improvement, staff and staffing, and the role of boards of directors in quality assurance – means that there are a variety of other empirical topics that could be further investigated. For some of these topics (e.g. the use of patient feedback in scorecards and the performance management of services within trusts; the use of patient feedback within CQUINs and contracts between commissioners and providers of hospital services) I

have collected data from Hillside and Northbank Hospitals that could be further analysed. For other topics (e.g. the use of feedback about clinical treatment and non-clinical aspects of patient experience, the use of feedback generated by internet or social media based sources of information) I have a small amount of data from Hillside and Northbank Hospitals but further, focused data collection would be needed to support a substantial analysis. Of these topics, the most immediately important from the perspective of health care and health is the use of feedback about diagnosis and treatment; further research would link not only to policy and research about patients who are 'experts by experience' and about patient reported outcome measures but also to questions about the role and accountability of clinical professions to the individual patients for whom they provide services (McDonald et al. 2013, Reader et al. 2014, Black et al. 2014). The most important of these topics from the perspective of public management more generally is the use of feedback from patients in the formal performance monitoring and management of services within Trusts; further research in this area would focus on the ways in which feedback is used in the context of operational targets and performance management more generally (Pollitt and Bouckaert 2004, Bevan and Hood 2006). Both issues would repay further study.

In writing this thesis I have been aware that much of the feedback about which I have presented data was derived from surveys of patients, complaints, patient involvement forums, and face-to-face contact between patients and clinical practitioners and managers. Less use was made at Hillside and Northbank Hospitals in 2011 of patient feedback collected electronically from kiosks or terminals installed locally within hospitals, from the internet, or from electronic social media. Although there is potentially useful research that would simply identify and map the different ways in which feedback is collected through these media, this mapping would not be the most important issue from the perspective of the use of feedback. The interesting question would be whether these sources of immediate 'real-time' feedback are in fact used in real time to identify and resolve problems in patient experience and the provision of services, in the same way as clinical systems may provide feedback to doctors to guide the treatment of patients. If real-time feedback is used in this way, a further question arises as to whether this immediate use of feedback complements or replaces the use of feedback to influence the strategic direction and medium term priorities of trusts (Larsson 2006, Brown et al. 2009). The risk is that attempts to maximise the immediate satisfaction of patients may displace longer-term benefits and outcomes, an issue that itself brings us back to questions about the criteria and

standards that managers use to guide the use of feedback and assess the quality of services.

In Chapter 2 of this thesis I drew on a variety of empirical studies and reviews, starting with the ground-breaking research of Tasa et al. (1996) and including the policy review of Coulter et al. (2009) to begin to develop systematic listings and classifications of the sources, domains and uses of patient feedback and of the relationships between these different sources, domains and uses. In Section 7.2.4 in this chapter I explained why in analysing data and presenting the results in this thesis I had instead focused on the in-depth analysis of individual examples and uses of feedback. In depth analysis provides more immediate insights and understanding than the development of broader and systematic classifications. But there is a strong case to be made for further research to establish and develop the systematic classification of the uses of feedback (Brown et al. 2009, Coulter et al. 2009). In developing this line of research, the easier approach might be to start with the different kinds or sources of feedback. But, consistent with my original argument at the start of this research that far more attention has been paid to the collection than to the use of feedback, my view now is that further research should focus first on building up a comprehensive analysis and systematic classification of all the different uses, in clinical and non-clinical settings, of patient feedback. This, again, would take us into the heart of the interactions between patients, clinical practitioners and managers in the delivery and management of health care.

One of the main themes of this thesis has been the use of patient feedback to improve health care and health services. I have shown in Chapter 4 and argued in Section 7.2.1 in this chapter that, although improvement is seen by policy-makers, practitioners and researchers alike as being the goal of patient feedback, there has been in this context very little systematic research or analysis of what is meant by improvement. Building on my findings here, further research should investigate more closely the relationships between what policy-makers, managers and clinicians say are the aims of improvement, the ways in which they assess and reports the actual results of specific improvement initiatives, and the criteria and standards of improvement that are built into the routine measurement and performance management systems within NHS trusts and other health care organisations. My initial findings here suggest that further research would identify significant inconsistencies within and between each of these three domains. This research would then link with and contribute to the health service improvement and

improvement science literatures more generally (Dixon-Woods et al. 2012, Marshall et al. 2013, Braithwaite et al. 2014).

In this thesis I have drawn on the patient feedback research literature and presented for the first time findings about two specific issues: the use of patient feedback to influence and manage clinical and non-clinical staff; and the use of patient feedback by the boards of directors of NHS trusts to help assure the quality of services and for other purposes. The management of staff and the role of boards are both issues of major importance in the provision of health services. Further research is needed to extend and test my findings in other health service organisational and settings. And, to take the research forward from a descriptive to a more analytical stage, future studies should draw not simply on the patient feedback research literature but also on the extensive literatures about the motivation and management of staff and about quality assurance and the roles of boards of directors in health service and other public and private sector organisations.

I have emphasised in this chapter the empirical focus of the research I have undertaken. Further insights will come not only from the continuation of this empirical focus in the ways I have outlined above, but also by developing and strengthening theoretical frameworks for the analysis and explanation of the use of patient feedback. Theory relates in the first instance to analysis of patient feedback as one component of a spectrum or mosaic of patient and public involvement activities in health services or public service more generally (Bate and Robert 2006, Tritter and McCallum 2006, Tritter 2009, Fotaki 2011a). But, as I have suggested above, it should also be analysed as part of the management and organisational processes in health and public services more generally; how do feedback from patients and other forms of user involvement relate to management targets and other performance management systems? And more generally, how does the use of feedback, as a form of consumer influence in public services, relate to the central government and regulatory control of health services? (Moran 2003, Osborne 2010, Dohler 2011, Bevir 2011a) It is by addressing these questions in the context of public management theory that future research will provide a fuller understanding not only of how feedback from patients is used but also of the more difficult, longer-term question of why feedback from patients is used in the management of health services.

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Abbreviations and Acronyms

A and C	Administrative and Clerical
A and E	Accident and Emergency
AHP	Academic Health Partners
ARC	Assurance and Risk Committee
CAG	Clinical Academic Group
CHC	Community Health Council
CNS	Clinical Nurse Specialist
CoG	Council of Governors
CQC	Care Quality Commission
CQUIN	Commissioning for Quality and Innovation
DH	Department of Health
DNA	Did Not Attend
EMSA	Eliminating Mixed Sex Accommodation
ESRC	Economic and Social Research Council
FFT	Friends and Family Test
FT	Foundation Trust
GP	General Practitioner
HRWD	How Are We Doing
IoM	Institute of Medicine
IRAS	Integrated Research Application System
IT	Information Technology
LINKs	Local Involvement Networks
MP	Member of Parliament
MRSA	Methicillin-resistant Staphylococcus aureus
NHS	National Health Service
PALS	Patient Advice and Liaison Service

PCT	Primary Care Trust
PEAT	Patient Environment Action Team
PES	Patient Experience Standard
PEWG	Patient Experience Working Group
PFI	Private Finance Initiative
PICU	Paediatric Intensive Care Unit
PPI Forum	Patient and Public Involvement Forum
PROMs	Patient Reported Outcome Measures
R&D	Research and Development
SpR	Specialist Registrar
SSA	Single Sex Accommodation
TEAM	Trauma, Emergency and Acute Medicine
TME	Trust Management Executive
UK	United Kingdom
USA	United States of America

Appendix 1 Information and Consent Forms for Participants

Information for Participants

Consent Form

Comments, Compliments and Complaints: The Use of Patient Feedback in the Management of the National Health Service

Information for Participants in the Research Study

We would like to invite you to take part in this postgraduate research study. You should only participate if you want to. Choosing not to take part will not disadvantage you in any way. Before you decide whether you want to take part, it is important for you to understand why the research is being done and what your participation will involve. Please take time to read the following information and discuss it with others if you wish. Ask us if there is anything that is not clear or if you would like any more information.

Aim of the Research

The aim of the research is to understand how and why patient feedback in the form of comments, compliments and complaints is used in everyday practice in the management of the National Health Service in England. The research will help the Health Service make best use of feedback from patients and help service users and staff to be realistic about what feedback may and may not achieve.

Participation in the Research

The study is being conducted at two inner London acute general hospital NHS Foundation Trusts. We will collect data from the staff of these two trusts, not from patients or other people. Individual participants in the research are being selected on the basis of their involvement in patient feedback and / or the management of services within the Trust and their knowledge about how decisions are made. This includes people working at director and corporate levels, who have an overview of the trust as a whole, and people working in individual clinical and non-clinical services, where feedback impacts most directly on the management of patient services. If you do decide to take part in the research you will be given this information sheet to keep and will be asked to sign a consent form.

What Does Taking Part Involve?

You may be asked to take part in one of three ways: a one-to-one interview which will probably take about 45 minutes and which will be audio recorded; an informal discussion in which the researcher will take hand-written notes; or observation of a meeting or other working activity, again where the researcher will take hand-written notes. Recordings of interviews will be deleted when they have been transcribed.

Data collection will focus on the different kinds of patient feedback that are collected and used in the Trust, the organisational priorities and processes through which feedback is handled, and the ways in which feedback is used in the management of services. None of the information or research will relate to feedback from individually identifiable patients; it will relate only to statistical or summarised data about feedback.

Risks or Disadvantages of Taking Part

Participating in the study will take up a little of your working time. Interviews should last no more than about 45 minutes. Any one person is likely to be interviewed only once in the course of the study. The amount of informal discussion and other contact will vary from person to person. Every effort will be made to minimise interference with everyday working activities. If you say at any time that discussion or other participation is not convenient, that decision will be respected.

Benefits of Taking Part

The research will help the Health Service make best use of feedback from patients. The results of the research will be fed back to staff in the Trust, in ways to be agreed with senior managers, that should lead to improvements in services and strengthening good practice locally. And, hopefully, you will find it interesting and useful to yourself to share your experience and knowledge with the researcher.

Confidentiality and Anonymity

Your name and role will not be attached to any data you provide. All data from the study will be stored securely and will only be accessed by the researcher. You, your role and your workplace will be anonymised by the researcher and will not be identified by name in any reports of results or future publications.

Withdrawing from the Research

You are free to withdraw from the study at any time. You do not have to give a reason for withdrawing. If you withdraw from the study, any data that you provided that has not yet been analysed may also be withdrawn from the study. This analysis is expected to take about two weeks from the date the data was provided. Any data that has been analysed will not be withdrawn.

No Fault Compensation Scheme

If you believe that this study has harmed you in any way, you can contact King's College, London using the details below for further advice and information.

More Information about the Research

The research is being undertaken by Mr. Robert Lee as research towards PhD degree in the Department of Management at King's College, London. If you would like more information about the research, please contact him Robert.Lee@KCL.Ac.UK or one of his academic supervisors.

Dr Juan Baeza

Juan.Baeza@KCL.Ac.UK

020 7848 4634

Professor Naomi Fulop

Naomi.Fulop@KCL.Ac.UK

020 7848 4142

Comments, Compliments and Complaints: The Use of Patient Feedback in the Management of the National Health Service

Research Study Participation Consent Form: Individuals

Please read the following statements and initial the boxes to show that you agree

1. I confirm that I have read and understood the information sheet for this study. I have had the opportunity to consider the information and ask questions, and have had these answered satisfactorily. ☐
2. I understand that my participation is voluntary and that I am free to withdraw at any time without giving any reason, without my legal rights being affected. ☐
3. (a) I understand that data resulting from my participation in this interview will be audio recorded and stored anonymously. ☐
- OR
- (b) I understand that data resulting from my participation in this study will be recorded in writing and stored anonymously. ☐
4. I understand that data I provide may be used (anonymised fully) in future publication of this research. ☐
5. I understand that, if I withdraw from the study, the data that I provided and that has already been analysed will be retained (anonymised fully) for publication, but that any data that has not yet been analysed may be fully withdrawn by me from the study. ☐
6. I agree to take part in this study. ☐

Name of participant

Date

Signature

Name of person taking consent

Date

Signature

Appendix 2 Interview Guide (Directorate and Divisional Managers)

Comments, Compliments and Complaints: the Use of Patient Feedback in the Management of Health Services.

Phase 1 Interview Schedule

Interview Reference:

Interviewer:

Interviewee:

Date:

Start and End Times:

Introduction

Purpose of Interview

Information and Consent Forms

Patient feedback is any kind of information provided by a patient to service providers or anyone working on behalf of providers about the services that the patient has used.

1. Background

1.1 Please tell me about your job; outline the main responsibilities and how your role fits into the wider organisation.

To whom are you managerially accountable?

2. Patient Feedback

2.1 What are the main kinds of patient feedback that you are involved with in your job at divisional or directorate level? Can you simply identify them and list them for me.

3. Description and Uses of the Main Kinds of Feedback

For the main kinds of feedback identified in question 2.1 that the participant is personally involved in, get the participant to describe and define the feedback and how it is used. Depending on the role of the participant, this may relate to one

individual kind of feedback (e.g. a particular patient survey or complaints) or to the collated results of different kinds of feedback (e.g. in quarterly patient experience report).

For the main kinds of patient feedback that you are involved with:

3.1 *If not already established from previous interviews:* Who collects it and why?

3.2 *If not already established from previous interviews:* What kinds of topics or issues does it relate to?

3.3 How is the feedback collated and analysed? Who by?

3.4 Who looks at the feedback? Where does it go to? Talk me through the process relating to

- relationships between the Trust's corporate directors and your division / directorate
- at divisional or directorate level
- relationships with individual services within the division / directorate.

3.5 How is the feedback used? What decisions are made using the feedback

- in relationships between the Trust's corporate directors and your division / directorate
- at divisional or directorate level
- in relationships with individual services within the division / directorate?

4. Examples of Feedback

4.1 Can you give me one or two substantial examples where patient feedback has been used effectively in the management of services? Why did this happen?

And an example of where feedback might have been used but was not? And why didn't it happen?

Or, if the participant cannot give a clear example of this,

Can you give me an example of feedback where there were particular difficulties or problems in getting it used in the management of services?

5. Overview and Conclusion

- 5.1 Thinking about what you've been talking about, what are the main aims in the use of patient feedback in the Trust? What are people trying to achieve in collecting and using patient feedback?

- 5.2 How important is the use of patient feedback in the context of all the other things that people are trying to achieve? How does patient feedback fit in with other priorities in the Trust?

Thank you very much.

Appendix 3 Observation of Meetings

Introduction

This appendix contains a list of the names and dates of meetings observed during fieldwork. It also identifies the meetings of the Boards of Directors at which there was some mention or fuller comments in the discussion about patient feedback.

Hillside Hospital NHS Foundation Trust: Board of Directors Meetings Held in Public

Meetings held every month except August. Including the additional meeting to approve the Annual Report and Accounts, a total of 12 meetings.

Date of Meeting
January 25 th 2011
February 22 nd 2011
March 29 th 2011
April 29 th 2011
May 24 th 2011
June 2 nd 2011 *
June 28 th 2011
July 26 th 2011
September 29 th 2011
October 25 th 2011
November 29 th 2011
December 20 th 2011

* June 2nd 2011 (additional short meeting to approve annual report and accounts and receive auditors' reports)

Each meeting scheduled on the agenda to last about two hours with specific times allocated for each agenda item. My observation notes record that meetings lasted between 1¾ and 2¼ hours.

Hillside Hospital Performance Review and Other Trust Management Meetings

Internal management meetings held in private in Trust offices.

Meeting	Date
Critical Care Performance Meeting	26 th October 2011
TEAM Performance Meeting	26 th October 2011
Women and Children's Performance Meeting	30 th November 2011
Networked Services Performance Meeting	30 th November 2011
Renal Nursing Scorecard Meeting	15 th December 2011
Liver Nursing Scorecard Meeting	15 th December 2011
TEAM Nursing Scorecard Meeting	20 th January 2012

Hillside Hospital Other Meetings

Meeting	Date
Council of Governors Patient Experience Sub Committee	8 th November 2011
Council of Governors Meeting	1 st December 2011.

Northbank Hospitals NHS Foundation Trust: Board of Directors Meetings Held in Public

Meetings in public held every other month from January onwards, with additional meetings in April and December, making a total of eight meetings in 2011.

Date of Meeting
12 th January 2011
9 th March 2011
13 th April 2011
11 th May 2011
20 th July 2011
14 th September 2011
9 th November 2011
14 th December 2011

The meetings were not scheduled to last a particular time, but each one lasted (according to my observation notes of the last five meetings) between two and two and a half hours.

Northbank Performance Review and Other Trust Meetings

Internal management meetings held in private in Trust offices.

Meeting	Date
Chemotherapy Day Unit Observation and Meeting	14 th July 2014
'Safe in Your Hands' Meeting	19 th August 2011
Women's Performance Review Meeting	8 th September 2011
Women's Performance Review Meeting	29 th November 2011

**Hillside Hospital: Observation Notes Mentioning Patient Feedback at KCH
Board of Director Meetings in 2011**

Agenda Item / Paper	Jan	Feb	March	April	May	June	July	Sept	Oct	Nov	Dec
Annual Plan		✓			✓						
Chief Exec's Report		✓				✓		✓	✓		
Governance and Quality Committee											
Minutes								✓			
Patient Experience Report	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Performance Report	✓	✓						✓	✓	✓	
Quality Accounts		✓									
Quality Gov. Framework											
Transformation Programme		✓									
Finance	✓										
Quality Focus	✓		✓								
Estates			✓								
SSA / EMSA			✓								✓
Complaints Annual Report						✓					

**Northbank Hospitals: Observation Notes Mentioning Patient Feedback at KCH
Board of Director Meetings in 2011**

Agenda Item / Paper	Jan	March	April	May	July	Sept	Nov	Dec
Chief Exec's Report								
Performance Report and Scorecard								
C of G PEWG	✓				✓		✓	
Quality & Safety Report				✓				
Patient Experience / Quality Strategy		✓	✓		✓	✓		
Quality Accounts			✓					
Annual Plan								
Assurance and Risk Committee								
Minutes of Board Meeting								
SSA / EMSA	✓							
Finance		✓						
Presentations: Cancer; Women's				✓				✓

Appendix 4 Legislation, Department of Health Policy and Related Documents

Introduction

In Section 3.5.4 I stated that, as part of my reading to familiarise myself with government policy about the collection and use of patient feedback, I had read the legislation and a wide range of public documents published since 1997 containing government policy, Department of Health guidance or guidance and information produced by Monitor and the Care Quality Commission as regulatory bodies. This appendix identifies those documents that I have used as evidence or more indirectly in the preparation of this thesis.

Legislation

The Health and Social Care Act 2001.
The National Health Service Reform and Health Care Professions Act 2002.
Health and Social Care (Community Health and Standards) Act 2003.
The National Health Service (Complaints) Regulations 2004, SI 2004 No. 1768
The National Health Service Act 2006.
The Local Government and Public Involvement in Health Act 2007.
The Local Involvement Networks Regulations 2008, SI 2008 No. 528.
The Health and Social Care Act 2008.
The Local Authority Social Services and National Health Service Complaints (England) Regulations 2009 SI 2009 No. 309
The Health and Social Care Act (2008) Regulated Activities Regulations 2010, SI 2010 No. 781.

Department of Health Policy and Guidance

Department of Health (2000) <i>The NHS Plan. CM 4818-I</i> . London: HMSO.

Department of Health (2002) <i>Improvement, Expansion and Reform: the Next Three Years. Priorities and Planning Framework 2003 – 2006</i> . London: Department of Health.
Department of Health (2003) <i>Strengthening Accountability. Involving Patients and the Public. Policy Guidance Section 11 of the Health and Social Care Act 2001</i> . London: Department of Health.
Department of Health (2003) <i>Strengthening Accountability. Involving Patients and the Public. Practice Guidance Section 11 of the Health and Social Care Act 2001</i> . London: Department of Health.
Department of Health (2004) <i>The NHS Improvement Plan – Putting People at the Heart of Public Services. Cm 6268</i> . London: TSO.
Department of Health (2007) <i>The NHS in England: the Operating Framework for 2008/09</i> . London: Department of Health.
Department of Health (2007) <i>Making Experiences Count A New Approach to Responding to Complaints. A Document for Information and Comment</i> . London: Department of Health.
Department of Health (2008) <i>Operational Plans 2008/09 – 2010/11</i> . London: Department of Health.
Department of Health (2008) <i>High Quality Care for All. NHS Next Stage Review Final Report. CM 7432</i> . London: The Stationery Office.
Department of Health (2008) <i>Guidance on the Routine Collection of Patient Related Outcome Measures (PROMs) for the NHS in England 2009/10</i> . London: Department of Health.
Department of Health (2008) <i>Real Involvement. Working with People to Improve Health Services</i> . London: Department of Health.
Department of Health (2009) <i>Listening, Responding, Improving. A Guide to Better Customer Care</i> . London: Department of Health.
Department of Health (2009) <i>Understanding What Matters. A Guide to Using Patient Feedback to Transform Services</i> . London: Department of Health.
Department of Health (2009) <i>Listening, Responding, Improving – A Guide to Better Customer Care</i> . London: Department of Health.

Department of Health (2009) <i>NHS 2010 – 2015 From Good to Great. Cm 7775</i> . London: TSO.
Department of Health (2009) <i>The NHS Constitution</i> . London: Department of Health.
Sir David Nicholson Letter of 24th February 2010 to All NHS Chairs, Robert Francis QC Mid-Staffs Inquiry Report. Gateway Reference 13684 (downloaded 20th October 2014).
Department of Health (2010) <i>Equity and Excellence: Liberating the NHS. CM 7881</i> . London: TSO.
NHS England (2015) Introduction to the Friends and Family Test. http://www.england.nhs.uk/ourwork/pe/fft/ (accessed 2dn February 2015).

Monitor

NHS Foundation Trusts: Clinical Quality and Service Performance. September 2006 (downloaded 22 nd May 2012).
The NHS Foundation Trust Code of Governance 2010 (downloaded 22 nd May 2012).
Quality Governance Framework July 2010 (downloaded 22 nd May 2012).
Compliance Framework 2011/12. First Published 31 March 2011 and Updated on 19 September 2011 (downloaded 22 nd May 2012).
<i>Hillside Hospital</i> NHS Foundation Trust Directory and Constitution (Accessed May 2012).
<i>Northbank Hospitals</i> NHS Foundation Trust Directory and Constitution (Accessed May 2012).

Care Quality Commission

Guidance about Compliance: Summary of Regulations, Outcomes and Judgement Framework. March 2010 (downloaded 20th April 2012).
Guidance about Compliance: Essential Standards of Quality and Safety. March 2010, updated 2011 (downloaded 20th April 2012).

The State of Health Care and Adult Social Care in England: An Overview of Key Themes in Care 2010/11 (downloaded 22nd May 2012).
Review of Compliance <i>Hillside</i> Hospital NHS Foundation Trust. Date of Review 29th December 2010 (downloaded 16th April 2011).
Patient Survey Report 2009 Survey of Adult Inpatients in the NHS 2009 <i>Hillside</i> Hospital NHS Foundation Trust (downloaded 7th April 2011).
Patient Survey Report 2010 Survey of Adult Inpatients in the NHS 2010 <i>Hillside</i> Hospital NHS Foundation Trust (downloaded 23rd August 2011).
Patient Survey Report 2009 Survey of Adult Inpatients in the NHS 2009 <i>Northbank</i> Hospitals NHS Foundation Trust (downloaded 7th April 2011).
Patient Survey Report 2009 Outpatient Department Survey 2009 <i>Northbank</i> Hospitals NHS Foundation Trust (downloaded 7th April 2011).
Patient Survey Report 2010 Survey of Adult Inpatients in the NHS 2010 <i>Northbank</i> Hospitals NHS Foundation Trust (downloaded 23rd August 2011).

Strategic Health Authority

CQUIN Targets 2010/11 <i>Hillside Hospital</i> (downloaded 24 th May 2012) <ul style="list-style-type: none"> • Acute Hospital Services • Specialised Services.
CQUIN Targets 2010/11 <i>Northbank Hospitals</i> (downloaded 24th May 2012) <ul style="list-style-type: none"> • Acute Hospital Services • Specialised Services.

Other

Inside Your Hospital. Doctor Foster Hospital Guide 2001-2011 (downloaded 5 th January 2012).
National Cancer Patient Experience Programme 2010 National Survey: <i>Northbank Hospitals</i> (downloaded 4 th August 2012).
NHS England: <i>Introduction to the Friends and Family Test</i> . http://www.england.nhs.uk/ourwork/pe/fft/ (downloaded 4 th March 2015).

The Mid Staffordshire NHS Foundation Trust Inquiry (2010) Independent Inquiry into Care Provided by Mid Staffordshire NHS Foundation Trust January 2005 – March 2009 Chaired by Robert Francis QC. HC 375-1. London: The Stationery Office.

The Mid Staffordshire NHS Foundation Trust Public Inquiry (2013) Report of the Mid Staffordshire NHS Foundation Trust Public Inquiry. HC 898. London: The Stationery Office.

Appendix 5 Trust Documents

Introduction

In Chapter 3 I stated that I had examined all the Trust documents that were made available through the meetings in public of the Boards of Directors of Hillside and Northbank NHS Foundation Trusts in 2011 and through the trusts' public websites. In this appendix I identify those documents that I have actively used in one or more of three ways in the preparation of this thesis: as background information; as providing detailed technical or procedural information about the collection of use of feedback; or as material for detailed analysis and use in the findings chapters of this thesis.

Documents Used as Background Information

I used the documents listed here primarily to understand the context in which patient feedback was collected and used in the Trusts, rather than as sources of information about patient feedback itself.

Hillside Hospital

Agendas, papers and minutes of all meetings in public of the Board of Directors in 2011.
Hillside Hospital public website: home page and linked pages accessed 7 th April 2011 and subsequent dates up to December 2011 <ul style="list-style-type: none">• Always Aiming Higher• Get Involved• <i>Hillside</i> Values• In Your Shoes• Patient and Public Involvement• The Future• The Values Journey.
Annual Plan 2010/11.
Annual Report and Accounts 2010/11.
Quality Account 2010/11.
Annual Plan 2011/12.
Annual Report and Accounts 2011/12.
Trust Strategy 2011-14: Summary.

Northbank Hospitals

Agendas, papers and minutes of all meetings in public of the Board of Directors in 2011.
Northbank Hospitals public website: home page and linked pages accessed 7 th April 2011 and subsequent dates up to December 2011 <ul style="list-style-type: none">• Our 2020 Vision• Our Service Strategy• Our Values• Overview• Trust Management Executive• Vital Statistics• What's in the Pipeline.
Annual Plan 2010/11.
Annual Report and Accounts 2010/11.
Quality Accounts 2010/11.
Annual Plan 2011/12.
Annual Report and Accounts 2011/12.

Documents Used to Provide Technical Information about Patient Feedback

The documents listed here were (apart from those listed as being accessed from the Trusts' websites) given to me by interviewees. I used these documents primarily as sources of information and ideas about the collection and use of patient feedback in the two Trusts, but have not used them directly as evidence in the writing and presentation of this thesis.

Hillside Hospital

Comments and Suggestions (downloaded 7 th April 2011).
Complaints Codes.
Complaints Procedure: Information for Patients (downloaded 10 th April 2011).
First Choice Patient Experience Programme (downloaded 7 th April 2011).
How Are We Doing Outpatient Questionnaire.
How Are We Doing? (downloaded 15 th August 2011).
How Are We Doing? Comments and Suggestions Form.

How Are We Doing? Inpatient Questionnaire.
Maternity Care: Tell Us What You Think (downloaded 5 th January 2012).
PALS Codes.
Patient Advice and Liaison Service (PALS) (downloaded 7 th April 2011).
Patient Advice and Liaison Service Feedback Form (downloaded 7 th April 2011).
Policy for Patient Complaints Handling (downloaded 1 st April 2011).
Quality and Governance Report January to March 2011 to the Quality and Governance Committee 9 th May 2011.
Ward 20:20. PowerPoint presentation.

Northbank Hospitals

Clinical Indicators Meeting 4 th March 2011. Ipsos Mori Telephone Survey. A Summary of Key Results at Quarter 3 (2010/11).
Oncology, Haematology, Thoracic Surgery & Cellular Pathology Directorate Monthly Risk Management Report July 2011.
Patient Information Team (PIT) PIT/PALS Report for Q1 April - June 2011.
Patient Information Team (PIT) PIT/PALS Report for Q3 October – December 2010.
Patient Surveys: Meridian Survey Completion Forms (Inpatients and Outpatients) (downloaded 7 th April 2011).
Patient Surveys: Meridian Survey Completion Forms (Maternity, Child Outpatients, Dental Day Cases, Accident and Emergency) (downloaded 15 th December 2011).
Quality and Patient Safety Report Quarter 3: Report to End of December 2010.
Real Time Patient Feedback: An Overview. September 2011.
Showing We Care: Service Standards Workshop. A report upon the findings of patient workshop research conducted by <i>Northbank Hospitals</i> NHS Foundation Trust, July 2011.
Survey of Inpatients, Day Case Patients, and Day Surgery Patients Wave 3 2010/11.
Trust-wide Reactive Risk Quarter 3 Report to Clinical Governance and Risk Management Committee 24 th February 2011.

Documents about Patient Feedback Used as Sources of Data in This Thesis

I have used these documents to provide specific evidence or make or develop specific arguments about the thematic analyses that form the basis of the findings

chapters of this thesis. I therefore list the documents under the headings of these three chapters

Chapter 4 Improving Hospital Services

Hillside Hospital

Hillside Hospital public website: home page and linked pages accessed 7 th April 2011
<ul style="list-style-type: none"> • <i>Hillside</i> Values.
Performance Reports to the meetings of the Board of Directors in 2011.
Patient Experience Reports to the meetings of the Board of Directors in 2011.
Quality Account 2010/11.
Food@ <i>Hillside</i> . Part of 'Improving Patient Experience' Project, Transformation Programme 2011. Report to Board of Directors meeting March 2011.

Northbank Hospitals

Performance Reports to the meetings of the Board of Directors in 2011.
Chief Executive's Scorecard reports to the meetings of the Board of Directors in 2011.
Quality Accounts 2010/11.

Chapter 5 Influencing and Managing Staff

Hillside Hospital

<i>Hillside</i> Awards (downloaded 14 th December 2011).
Hillside Hospital Staff Commendation Nomination Form (downloaded 15 th July 2011).
<i>Hillside</i> Commendation: Scheme for Recognising Outstanding Contributions to Patient Care (downloaded 15 th July 2011).
<i>Hillside</i> Hospital NHS Foundation Trust Summer 2011 <i>Hillside</i> Commendation Awards: Citations (downloaded 15 th July 2011).
Performance Report: Month 7 Performance. Report to meeting of Board of Directors in November 2011.
<i>Hillside</i> Patient Experience Report October 2011. Report to meeting of Board of Directors in November 2011.

Northbank Hospitals

Care Awards Nomination Form (downloaded 13 th December 2011).
The CARE Awards (downloaded 15 th December 2011).
Trust Annual Awards Nomination Form (downloaded 13 th December 2011).

Chapter 6 Boards of Directors

Hillside Hospital

Hillside Hospital public website: home page and linked pages accessed 7 th April 2011 <ul style="list-style-type: none">• <i>Hillside</i> Values• Board of Directors• Committees of the Boards of Directors.
Agendas, papers and minutes of meetings in public of Board of Directors in 2011 including <ul style="list-style-type: none">• Chief Executive's Reports• Performance Reports• Patient Experience Reports.
Quality Focus: Francis Report on the Mid-Staffordshire NHS FT: report to meeting of Board of Directors in March 2010.
Annual Plan 2010/11.
Governance Committee and Quality and Governance Committee Annual Report April 2010 to March 2011: report presented to meeting of Board of Directors in April 2011.

Northbank Hospitals

Agendas, papers and minutes of meetings in public of Board of Directors in 2011 and 2012, including <ul style="list-style-type: none">• Chief Executive's Reports and Scorecards• Performance Reports.
Response to the Report of the Mid Staffordshire Inquiry. Report to meeting of Board of Directors in April 2010.
Involving and Listening to Patients: A Trust Framework. Report to meeting of Board of Directors in July 2010.
Briefing Paper: Overview of PALS Data; Understanding the Patient Experience: Key Themes from Complaints, PALS and Surveys. Reports to meeting of Council of Governors Patient Experience Working Group November 2010.
Council of Governors' Report: Meeting Held on 1 st December 2010. Report to meeting of Board of Directors in January 2011.
Council of Governors' Report: Patient Experience Working Group Report Meeting Held on 25 th November 2010. Report to Board of Directors in January 2011.

Patient Experience Report. Report to meeting of Board of Directors in March 2011.
Improving Out Patient Experience. Report to meeting of Board of Directors in April 2011.
Improving the Patient's Experience Update Report. Report to meeting of Board of Directors in July 2011.
'Showing We Care' Quality Strategy 2011 – 2013. Report to meeting of Board of Directors in September 2011.
Assurance and Risk Committee: Minutes of the Meeting Held on 31 st August 2011. Report to meeting of Board of Directors in November 2011.
Assurance and Risk Committee: Minutes of the Meeting Held on 14 th December 2011. Report to meeting of Board of Directors in January 2012.
Quality & Patient Safety Report Quarter One Report to End of June 2011. Report to meeting of Board of Directors in July 2011.
Patient Safety and Experience Report Quarter 4 December 2011 to February 2012. Report to meeting of Board of Directors in April 2012.

Appendix 6 Coding Frame

The coding frame I used as the basis for analysing data for this thesis was based on five domains:

- the kinds or sources of patient feedback;
- the domains of patient feedback
- the uses of patient feedback;
- the aims of using patient feedback; and
- organisational processes in the use of patient feedback.

This appendix lists the main codes and where relevant the sub-codes in each of these five domains.

KINDS OR SOURCES OF PATIENT FEEDBACK	
Main Code	Sub-code
Internal Trust Sources	
Comments	
Complaints	
Compliments or Commendations	
Electronic Real-time Feedback	
Focus or User Groups	
Governors or Non-executive Directors	
Letters or Cards	
Local Surveys	Northbank Ipsos Mori Survey
	Hillside How Are We Doing? Survey
	Other Local Surveys
Other	
PALS	
Patients' Diaries	
Patients' Stories	
Trust Service Improvement Initiatives	Cancer Centre

	End of Life Care
	Food Service
	Go and See Visits
	Hourly Ward Rounds
	In Your Shoes Events
	Out-patient Improvement
	Quality Rounds / Ward 20 20 Initiative
	Ward Accreditation and PEAT Inspections
Feedback from Outside the Trust	
Community Groups	
GPs	
MPs	
National Surveys of Patients	National Survey of In-patients
	National Survey of Cancer Patients
	Maternity Services Survey
	National Out-patient Survey
	National A and E Survey
NHS Choices Website	
Patient Groups and Associations	
Press Reports	
PROMs	

DOMAINS OF PATIENT FEEDBACK	
Main Code	Sub-code
Access and Waiting Times	
Appointments and Admissions	
Care on the Ward	
Clinical Care and Treatment	

Communication	
Discharge Arrangements	
Food and Feeding	
'Hotel' Services and Hospital Environment	
Information (and Its Communication)	
Organisation and Delivery of Care	
Other	
Privacy and Dignity	
Single Sex Accommodation	
Staff Attitude, Behaviour and Communication	
Telephones and Contacting the Hospital	

USES OF PATIENT FEEDBACK	
Code	Sub-code
Action or Action Planning	
Assessing Issues or Concerns	
Assurance	
Business Planning	
Context	
Development Initiatives	
Improving Services Generally	
Improving Services: Specific Initiatives	
Monitoring	
Other	
Preventing Problems	
Putting Things Right	
Staff	Address Issues with Staff

	Communicate with Staff
	Learning
	Manage Staff
	Motivation and Morale of Staff
	Performance Management or Disciplinary Action
	Praise or Thank Staff
	Publicise Feedback to Staff
	Staff Appraisal, Portfolio or Personnel Record
	Staff Commendation Scheme
	Training or Education of Staff
Supporting Good Practice	

AIMS OF USING PATIENT FEEDBACK	
Main Code	Sub-codes
Organisational Aims	Compliance
	Benchmarking
	Other
	Reputation
	Successful Trust
Patient-related Aims	Better Care or Services for Patients
	Better for Patients
	Happy or Satisfied Patients
	Other
	Patient Choice
	Patient Experience
	Patient-centred Care
	Patients as Customers

	Patients as People
	Patients' Expectations or Preferences
	Patients' Feelings about Care or Services
	Patients Generally
	Patients' Needs or Interests
	Patients' Subjective Feelings
	Patients' Wants
Service-related Aims	Better Use of Resources
	Other Service Aims
	Quality of Care or Services Generally
	Quality of Clinical Treatment and Care
	Quality of Non-clinical services
	Safety

ORGANISATIONAL PROCESSES IN THE USE OF PATIENT FEEDBACK	
Main Code	Sub-codes
Board of Directors	
Committees of the Board	
Other Organisational Processes	
Performance Management	
Regulatory Requirements and External Targets	
Scorecards and Reports	

FOUR EXAMPLES OF THE USE OF PATIENT FEEDBACK	
Main Code	Sub-codes
Cancer Services at Northbank Hospitals	2010 National Cancer Survey
	Chemotherapy Day Unit
Neurosciences at Hillside Hospital	
Out-patient Improvement at Northbank Hospitals	
Food and Feeding at Hillside Hospital	